

CONFIDENTIAL

VOLUME II

MEDICAL SERVICES COMMITTEE

MINUTES
OF
EVIDENCE

April 1919



CALCUTTA
SUPERINTENDENT GOVERNMENT PRINTING, INDIA
1920



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MEMORANDUM FOR THE RECORD

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MEDICAL SERVICES COMMITTEE

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REPORT OF THE MEDICAL SERVICES COMMITTEE.

Volume I.—The Report and Annexures.

Volume II.—Minutes of evidence.

Volume III.—Questions and schemes circulated to witnesses, and certain papers placed before the Committee.



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CONTENTS OF VOLUME II.

	PAGES.
Minutes of evidence	1—300
Memoranda submitted by co-opted members of the Medical Services Committee	302-303
Communications received from Local Governments and various bodies and individuals whose oral evidence was not taken by the Committee	308-351
Paper on the promotion of hygiene and the prevention of malaria and other diseases by co-operation, by the Hon'ble Mr. P. C. Mitter, C.I.E.	352-355

LIST OF WITNESSES EXAMINED BEFORE THE MEDICAL SERVICES COMMITTEE.

	PAGE.
At DELHI, Tuesday, 11th February 1919.	
Lieutenant-General Sir H. HUDSON, K.C.B., C.I.E., Adjutant General in India	1
Dr. (Miss) K. A. PLATT, M.D., B.S., Principal, Lady Hardinge Medical College, Delhi	5
At DELHI, Friday, 14th February 1919.	
Lieutenant-Colonel R. A. NEEDHAM, D.S.O., I.M.S., Deputy Director-General, Indian Medical Service	7
Lieutenant-Colonel H. AUSTEN SMITH, C.I.E., I.M.S., Surgeon to His Excellency the Viceroy	9
Lieutenant-General Sir T. J. O'DONNELL, K.C.I.E., C.B., D.S.O., A.M.S., Director, Medical Services in India	13
At DELHI, Saturday, 15th February 1919.	
Major E. H. V. HODGE, I.M.S., Deputy Assistant Director, Medical Services, Army Headquarters, India	15
Lieutenant-Colonel CORRIE HUDSON, D.S.O., I.M.S., Officer Commanding, Indian Station Hospital, Ambala	16
Major W. H. PIERPOINT, I.M.S., Officer Commanding, Indian Troops War Hospital, Ambala	19
Captain THAKUR, I.M.S., Indian Station Hospital, Ferozépore	21
At DELHI, Monday, 17th February 1919.	
The Hon'ble Major-General W. R. EDWARDS, C.B., C.M.G., M.D., I.M.S., Director-General Indian Medical Service	24
At DELHI, Tuesday, 18th February 1919.	
Mr. H. B. HOLMES, Controller of Traffic, Railway Board, Government of India	34
Major W. R. DURHAM, I.M.D., in sub-medical charge, British Station Hospital, Ambala	34
2nd-class Assistant Surgeon G. W. DOYLE, I.M.D., Officers' Hospital, Abbottabad	35
At DELHI, Wednesday, 19th February 1919.	
Lieutenant-Colonel F. A. SMITH, I.M.S., Chief Medical Officer, Central India	37
Lieutenant-Colonel P. B. HAIG, C.B., I.M.S., Civil Medical Officer, Rajputana	41
At DELHI, Thursday, 20th February 1919.	
Lieutenant-Colonel J. W. LANGSTAFF, D.S.O., R.A.M.C., Assistant Director, Medical Services, Army Headquarters, India	44
Dr. BHAGAT RAM SAWHENBY, M.B., B.S. (Durham), M.R.C.S. (England), L.R.C.P. (London), L.M.S. (Punjab), Rai Sahib, Chief Medical Officer, Maler Kotla State, Member, Punjab Medical Council	46
Civil Assistant Surgeon CHAUDHURI MELA RAM, B.A., M.B., North Western Railway, Lahore	48
Civil Sub-Assistant Surgeon LALA KHAZAN CHAND, Rai Sahib, M.P.L., Central Malaria Bureau, Kasauli, Provincial Secretary (Punjab), All-India Sub-Assistant Surgeons' Association	50
Major F. NORMAN WHITE, C.I.E., M.D., I.M.S., Sanitary Commissioner with the Government of India	54
Captain J. C. BLAIKIE, R.A.M.C., British Station Hospital, Meerut	55
At DELHI, Friday, 21st February 1919.	
The Hon'ble Colonel R. C. MACWATT, C.I.E., I.M.S., Inspector-General, Civil Hospitals, Punjab	56
Lieutenant-Colonel D. W. SUTHERLAND, C.I.E., I.M.S., Principal and Professor of Medicine, King Edward Medical College, Lahore	61
Captain H. STOTT, I.M.S., Indian Station Hospital, Bannu	65
The Hon'ble Khan ZULFIQAR ALI KHAN, C.S.I.	71
At DELHI, Saturday, 22nd February 1919.	
The Hon'ble Colonel R. C. MACWATT, C.I.E., I.M.S., representing the views of the Government of the Punjab	72
Dr. B. T. HOLLAND, M.B., F.R.C.S., Residency Surgeon, and Chief Medical Officer, Baluchistan	74

	PAGE.
At LUCKNOW, Monday, 24th February 1919.	
Civil Assistant Surgeon B. N. VIJAS, Rai Bahadur	77
Major J. W. D. MEGAW, I.M.S., Professor of Pathology, and temporary Principal, King George's Medical College, Lucknow	81
Major G. C. L. KERANS, D.S.O., I.M.S., Deputy Assistant Director, Medical Services (Mobilization), 8th (Lucknow) Division	86
Captain J. L. SEN, M.C., I.M.S., Indian Station Hospital, Benares	87
Second Class Senior Military Sub-Assistant Surgeon ABDUL GAFOOR, Indian Station Hospital, Allahabad	89
At LUCKNOW, Tuesday, 25th February 1919.	
The Hon'ble Colonel C. MACTAGGART, C.I.E., I.M.S., Inspector-General of Civil Hospitals, United Provinces, and representative of the United Provinces Government	91
The Hon'ble SAIYID WAZIR HASAN, Advocate, Judicial Commissioner's Court, Lucknow	100
Lieutenant-Colonel W. YOUNG, I.M.S., Civil Surgeon, Cawnpore	102
Lieutenant-Colonel E. J. O'MEARA, F.R.C.S., I.M.S., Civil Surgeon, and Principal, Medical School, Agra	104
Civil Sub-Assistant Surgeon SAIYID ZAHID HUSAIN, Khan Sahib, Allahabad, Provincial President (United Provinces), All-India Sub-Assistant Surgeons' Association	108
At LUCKNOW, Wednesday, 26th February 1919.	
Lieutenant-Colonel J. M. CRAWFORD, O.B.E., I.M.S., Civil Surgeon, Benares	111
Dr. R. K. TANDON, Lucknow	114
Dr. M. N. OHEDAR, Rai Bahadur, Lucknow	118
Dr. S. L. SHARMA, President, All-India Sub-Assistant Surgeons' Association	123
Dr. D. R. RANJIT SINGH, I.M.S. (honorary temporary captain, I. M. S.), Allahabad	125
Major N. D. WALKER, R.A.M.C., Deputy Assistant Director, Medical Services (Sanitary), 8th (Lucknow) Division	128
At PATNA, Thursday, 27th February 1919.	
Major M. H. THORNELLY, I.M.S., Officiating Civil Surgeon, Cuttack	130
Dr. G. W. THOMPSON, Jheriah Board of Health	132
Dr. S. M. LIVESAY, Officiating Civil Surgeon, Darbhanga	133
Civil Assistant Surgeon PREMA NANDA DAS, F.R.C.S. (Edin.), Acting Civil Surgeon, Puri	134
At PATNA, Friday, 28th February 1919.	
Colonel G. J. H. BELL, C.I.E., I.M.S., Inspector-General of Civil Hospitals, Bihar and Orissa	136
Lieutenant-Colonel C. E. SUNDER, I.M.S., Civil Surgeon, Patna	143
At CALCUTTA, Monday, 3rd March 1919.	
Lieutenant-Colonel W. D. HAYWARD, I.M.S., Medical Storekeeper to Government, Calcutta	149
Captain R. KNOWLES, I.M.S., Director, Pasteur Institute, Shillong, Representing the Government of Assam	151
The Hon'ble Major-General W. H. B. ROBINSON, C.B., I.M.S., Surgeon-General with the Government of Bengal	155
At CALCUTTA, Tuesday, 4th March 1919.	
Dr. W. W. KENNEDY, M.D. (London), Calcutta	161
Dr. C. C. BOSE, Chief Medical Officer, Eastern Bengal Railway	162
Civil Sub-Assistant Surgeon SATKARI GANGULI, Kurigram, Rangpur, Bengal	162
At CALCUTTA, Wednesday, 5th March 1919.	
Civil Assistant Surgeon K. K. CHATTERJI, F.R.C.S. (Ireland), Calcutta	165
Lieutenant-Colonel J. T. CALVERT, C.I.E., I.M.S., Principal, Medical College, Calcutta	166
Dr. S. P. SARBADHIKARI, C.I.E., B.A., M.D., President, Bengal Medical Association	169
Lieutenant-Colonel Sir W. BUCHANAN, I.M.S., Inspector-General of Prisons, Bengal	173
At CALCUTTA, Thursday, 6th March 1919.	
The Hon'ble Mr. P. C. MITTER, C.I.E., Calcutta	177
Sir KAILAS CHANDRA BOSE, Kt., C.I.E., O.B.E., I.M.S., Calcutta	178
Dr. M. N. BANERJEE, B.A., M.R.C.S., Calcutta	180

At CALCUTTA, Friday, 7th March 1919.

Colonel P. C. H. STRICKLAND, Inspector-General of Civil Hospitals, Burma	183
Major R. D. SAIGOL, I.M.S., Burma	189
Civil Assistant Surgeon M. L. KUNDU, M.B., Burma	191
Lieutenant-Colonel Sir LEONARD RODGERS, Kt., C.I.E., F.R.S., M.D., F.R.C.P., F.R.C.S., I.M.S.	193

At MADRAS, Monday, 10th March 1919.

Lieutenant-Colonel F. E. SWINTON, C.I.E., I.M.S., Medical Storekeeper to Government, Madras	196
---	-----

At MADRAS, Tuesday, 11th March 1919.

Lieutenant-Colonel A. MILLER, M.B., I.M.S., Principal, Medical College, Madras	201
Dr. N. VENKATASWAMI CHETTI, M.B., C.M., Madras	206
Senior Grade Civil Sub-Assistant Surgeon S. BALASUBRAMANYA NADAR, Government Maternity Hospital, Madras.	211
Dr. A. LANKESTER, M.D., Director, His Exalted Highness the Nizam's Medical Department, Hyderabad, Deccan	212
Dr. M. KESAVA PAI, M.D., C.M., Acting Assistant Director, King Institute, Guindy	217
Rao Sahib U. RAMA RAO, Madras Branch, All-India Sub-Assistant Surgeons' Association	218
No. 1328 First Class Sub-Assistant Surgeon P. A. CHENGALVARAYAN, I.M.D., Secunderabad	221

At MADRAS, Wednesday, 12th March 1919.

Major F. F. ELWES, C.I.E., M.D., I.M.S., First Physician, General Hospital, Madras	223
Major J. F. GIBSON, I.M.D., Station Hospital, Madras	227
No. 1285 First Class Sub-Assistant Surgeon P. ANANTHANATHAN PILLAI, I.M.D., Bangalore	228
Major-General C. C. MANIFOLD, C.B., C.M.G., Deputy Director, Medical Services, 9th (Secunderabad) Division, Bangalore	230
Major A. W. J. LYNSDALE, I.M.D., Medical College, Madras	237

At MADRAS, Thursday, 13th March 1919.

Dr. M. R. GURUSWAMI MUDALIYAR, B.A., M.B., C.M., Acting Second Physician, General Hospital, Madras	239
The Hon'ble Lieutenant-Colonel W. J. NIBLOCK, M.B., F.R.C.S., I.M.S., Officiating Surgeon-General to the Government of Madras, representing the Government of Madras	242
Dr. T. T. THOMSON, M.B., CH.B., London Mission Hospital, Jammalamadugu	245
The Hon'ble Diwan Bahadur A. SUBBARAYALU REDDI GARU, B.A., B.L., Cuddalore	247
The Hon'ble Sir FAIRLESS BARBER, United Planters' Association of Southern India, Ootacamund	249

At BOMBAY, Monday, 17th March 1919.

Lieutenant-Colonel A. STREET, M.B., F.R.C.S., I.M.S., Senior Medical Officer, Jamsetjee Jejeebhoy Hospital, Bombay	251
Colonel F. A. F. BARNARDO, C.I.E., I.M.S., Assistant Director, Medical Services, Embarkation Staff, Bombay	254

At BOMBAY, Tuesday, 18th March 1919.

Mr. KAMAKSHI NATARAJAN, B.A., Editor of the <i>Indian Social Reformer</i> , Bombay	264
Major W. S. J. SHAW, M.D., I.M.S., Superintendent, Central lunatic asylum, Yeravda, Poona	265
Major W. TARR, M.D., F.R.C.S., I.M.S., Civil Surgeon, Jubbulpore	269
Civil Assistant Surgeon W. V. KANE, B.A., L.M. & S., Civil Surgeon, Nimar, Central Provinces	270

At BOMBAY, Wednesday, 19th March 1919.

Major C. F. MARR, M.B., I.M.S., Medical Storekeeper to Government, Bombay	274
Dr. W. W. NUNAN, M.D., Honorary Temporary Captain, I.M.S., Bombay	276
Dr. SORAB K. NARIMAN, M.D., B.Sc., L.M. & S., Bombay	277
Dr. SURJU PRASAD, Rai Bahadur, General Secretary, All-India Sub-Assistant Surgeons' Association	281

At BOMBAY, Thursday, 20th March 1919.

The Hon'ble Colonel C. R. M. GREEN, M.D., D.P.H., F.R.C.S., I.M.S., Inspector-General of Civil Hospitals, Central Provinces and Berar	283
Civil Assistant Surgeon E. S. BHARUCHA, L.M. & S., Khan Bahadur, Assistant to the Civil Surgeon, Poona	287
Dr. K. G. LAHOKARE, B.A., Poona	293
Dr. N. H. CHOKSY, M.D., Khan Bahadur, Bombay Medical Union	296

	PAGE.
At BOMBAY, Friday, 21st March 1919.	
The Hon'ble Major-General W. E. JENNINGS, M.D., I.M.S., Surgeon-General with the Government of Bombay	301
Dr. R. Row, M.D., D.Sc., Honorary Temporary Lieutenant-Colonel, I.M.S., Bombay	310
Sir M. B. CHAUBAL, K.C.I.E., C.S.I.	313
Dr. MIRZA YAQUB BEG, L.M. & S., Representative of the Punjab Medical Union	314
The Hon'ble Mr. G. S. CURTIS, C.S.I., I.C.S., Ordinary Member of Council, Bombay	318

MEDICAL SERVICES COMMITTEE.

MINUTES OF EVIDENCE

TAKEN BEFORE THE

MEDICAL SERVICES COMMITTEE

At Delhi, Tuesday, 11th February 1919.

PRESENT:

THE HON'BLE SIR VERNEY LOVETT, K.C.S.I., I.C.S. (*President*).

MAJOR-GENERAL G. CREE, C.B., C.M.G., A.M.S.

MAJOR-GENERAL P. HEHIR, C.B., C.M.G., C.I.E.,
I.M.S.

MAJOR-GENERAL H. HENDLEY, K.H.S., I.M.S.

THE HON'BLE MAJOR-GENERAL G. G. GIFFARD,
C.S.I., I.M.S.

S. R. HIGNELL, Esq., C.I.E., I.C.S.

LIEUTENANT-COLONEL A. SHAIRP, C.M.G., Indian
Army.

LIEUTENANT-COLONEL G. B. A. RIND, Indian Army.

MAJOR A. A. McNEIGHT, I.M.S. (*Secretary*).

LIEUTENANT-GENERAL SIR H. HUDSON, K.C.B., C.I.E., Adjutant General in India.

Written statement relating to the organization of the medical services in India.

"The Royal Army Medical Corps is maintained firstly, with a view to the prevention of disease, and secondly, for the care and treatment of the sick and wounded. The efficient performance of these duties demands a thorough knowledge of medical science which must be acquired and kept up by deep and continuous study, and any instruction in purely military questions, beyond what is required for the performance of his proper functions, must be regarded as superfluous for an officer of that corps.

"It is necessary, however, to remember that while these are the objects with which he is maintained, the interests of the army require something even more than professional scientific knowledge from an officer of the Royal Army Medical Corps, because it is impossible for him to carry out his duties efficiently without a certain general knowledge of military science, especially as regards the administration of an army in the field.

"For example, the work of officers of the Royal Army Medical Corps, includes the professional supervision of sanitary precautions; the collection of the sick and wounded, the compilation of records (general and professional) regarding them, certain arrangements in connection with the transportation of sick and wounded from the front, the discipline and maintenance of combatants under their charge, and the replenishment of medical and surgical requirements. Such duties bring the officers of the Royal Army Medical Corps, into close touch with the general work of the army. Moreover, in addition to their professional work, they have executive duties to perform, in their capacity as officers of the Royal Army Medical Corps units forming part of the army. For example, they are as much concerned as officers of other units in the provision of food, clothing and other requirements to their men, in the care and management of transport allotted to them, in

arranging their camps and movements, and fitting their units into their allotted places on the line of march, and, generally, in exercising the same functions as officers of other units, with the sole exception of actual combatant work.

"As regards actual tactics, while officers of the Royal Army Medical Corps are not charged with combatant duties, they are very intimately concerned in the combatant work of the other branches, and the efficient performance of their duties on the battlefield demands some knowledge of the general principles on which military operations are conducted. They must, for example, be capable of understanding from an operation order what is likely to be required of them."

The above extract from the handbook, Royal Army Medical Corps Training, describes briefly the duties of an army medical service in armies organised for modern war. It was written before the war, and though it lays stress on the necessity for administrative and military knowledge, the present war has shown us that the importance of these qualities has increased to a degree never before contemplated. It is no exaggeration to say that a staff and administrative officer of the medical services requires every bit as much training and experience as any other commanding and staff officer in the army. This training cannot be picked up at once, it cannot be hastily improvised, moreover it must be continuous if it is to keep abreast with modern improvements and developments.

Turning next to the manner in which such a service should be organised in peace to provide for war, we find that in general principles it differs but little from any other branch of the army in that the peace establishment should provide the smallest possible cadre for the fulfilment of its peace duties but sufficiently large to provide for expansion in war.

11 February 1919.]

Lieutenant-General Sir H. HUDSON.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

The manner in which such expansion is carried out differs somewhat from that of combatant branches. In the latter expansion is secured, primarily, from reserves and, as these become exhausted, by fresh enlistments. In the army medical services such reserves are few, and it is the practice to expand by importing the aid of civilian practitioners and so releasing army medical officers for the several administrative posts required in the chain of the medical services in the collecting, evacuating and distributing zones.

From the above we may deduce the two following conditions which should govern the organisation of the medical services of a State in relation to its requirements for war.

- (a) A permanent and highly trained army medical service.
- (b) A civilian source from which to expand (a) in war time.

Now it might be argued that the Indian Medical Service as at present organised, fulfils these conditions. It is true that it has both a military and a civil branch and that the latter provides a reserve for the former, but where it fails is that it does not provide a highly trained army medical service and that service in the military as opposed to the civil branch is not continuous. The organisation of the military branch is antiquated, and the system of regimental hospitals, deliberately discarded in the British Army some 40 years ago as both inefficient and uneconomic, is still maintained though it is in process of abolition in favour of the station hospital system.

There are no schools for the military and professional training of medical officers. Interchange of officers between the military and civil branches is permitted, but as there is little or no limit to the period for which an officer may be absent from military employ, it is found, in practice, that in the majority of cases he is of but little military value when he reverts. Again, on the outbreak of war the officers received from civil employ, having in many cases somewhat high military rank, find themselves placed in administrative positions, for which, from their want of training and experience, they are obviously unfitted. They have no power of command because they have had no opportunities for exercising it, they have to learn the principles of administration at a time when previous knowledge of such principles is all important. It is true that they may be specially clever physicians or surgeons, but these are qualities which, important as they are, take a comparatively low place in any military medical hierarchy. Accepting the conclusions arrived at in paragraph 5 above we require for India:—

- (a) A permanent army medical service.
- (b) A civilian medical service or source of supply of medical personnel.

(a) *A permanent Indian army medical service.* It is assumed that after the war the garrison of India will remain partly British and partly Indian; it may be assumed also that England will provide as at present, a sufficiency of Royal Army Medical Corps medical personnel for the British portion of the army. For the Indian portion of the army similarly an Indian Medical Service must be created, but it is important that these two services should be combined if we are to have unity of doctrine, command and control. I would not advocate an Indian Army Medical Corps alone to administer the whole army, for I hold that the presence of Royal Army Medical Corps officers in India, coming as they do for comparatively short tours of service and equipped with the latest home ideas cannot but exercise a beneficial effect on the service as a whole, in the same manner as the inclusion in our staff out here of a due proportion of officers of the

British services makes for the efficiency of the army as a whole. In the medical services in India there has in the past been a tendency in our organisations in the field to keep the two services apart. Admitting that in peace time it is necessary to have special separate provision for Europeans and Indians, and admitting too, the application in war of the same principles in the "distributing" and to a certain extent in the "evacuating" zones, it cannot be said that to enforce it in the "collecting" zone is either practical or practicable, and in all of the above cases unity of administration and command is the chief essential.

I think there should be an Indian Army Medical Corps and that, as at present, this should be supplemented by Royal Army Medical Corps officers. The uniform, terms of service, promotion, and pay in India for the two services should be identical, but officers who engage for permanent service in the Indian Army Medical Corps would receive special rates of pension and perhaps an extra monthly allowance for continuous service in India conditional concurrently on passing and keeping up certain language tests. As regards appointments, these would be on the same principles as obtain in the rest of the army, a due proportion being reserved for the British and Indian portion of the service, whilst the Director of the Medical Services might, like the Commander-in-Chief, belong to either the British or the Indian service.

Promotion up to and including the rank of lieutenant-colonel, and possibly colonel, to be within the establishment of the Corps: above that, in the Indian Army establishment of general officers. Entrance to the service would be by open competition.

(b) *A civilian medical service, etc.* The organisation of this would be for the Home Department to consider. It would probably consist of:—

- (a) An Imperial medical service.
- (b) Local medical services.

Service might either be permanent or on contract for a term of years; entrance by competitive examination or by acceptance of certain diplomas. The service in fact might be organised on the lines of the Public Works Department in which a portion are engaged for continuous service—some specialists—such as surveyors, architects or specialists on limited contracts—others on temporary contracts convertible into continuous service. Such a system has many advantages for it enables Government to keep abreast of the times by bringing out specialist advisers for short terms and for special objects. It gives an opportunity too for members of the medical profession at home or elsewhere who do not wish to undertake an Indian career but who wish to study tropical diseases.

In order to provide a reserve for the Indian Army Medical Service it should be made a condition of service that a member of the Indian Medical Service would be available for employment on mobilisation and similar conditions should be imposed on all private practitioners before they are licensed to practice in India. Whether it would not be in the interests of both the services to permit officers of the Indian Army Medical Service to serve in civil appointments for a strictly limited number of years and whether it is desirable that the Indian Medical Service would be responsible for the manufacture and supply of all drugs, medical stores, etc., for both services, are details for consideration in due course. Personally I would allow for a proportion of Indian Army Medical Corps officers being in civil employ for periods not exceeding five years and I would not object to their permanent transfer to civil employ, in the same manner as officers are now transferred to the Foreign Department.

I am open to argument.

LIEUTENANT-GENERAL SIR H. HUDSON, called and examined.

(President.) The witness stated that he had served in France for 2½ years 8 months as Brigadier, General Staff, Indian Corps and 22 months in command of a British division; he had therefore seen very little of the working of the Indian Medical Services in the collecting

zone, but he had seen a good deal of them in the evacuating zones, etc. He had about 38 years' total service, of which three years were in the British Army, and the rest in the Indian Army.

11 February 1919.]

Lieutenant-General Sir H. HUDSON.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

He held that no army medical officer could be said to be fit to hold an administrative position in an army in the field, unless he had put in most of his service in military employ, as he would not be up to date in regard to modern improvements and developments. He referred, of course, to the higher command. The ordinary civil practitioner with hospital experience was quite capable of doing all the professional work in field medical units, etc., but, in regard to administrative work, such as the making of arrangements for the evacuation of the sick and wounded, it was necessary to have a man skilled in that particular line of work. In France they had had many prominent civilian doctors who used to work in the hospitals; but they had nothing to do with administration or the organization of the medical services.

Few Indian Medical Service officers had continuous military service. If an officer had been for a long time in civil employ he was not fit for any high position in the medical organization of an army in the field.

There were no schools in India, such as there were in England, for the military and professional training of medical officers.

In regard to his suggestion that the two medical services for the British and the Indian portions of the army should be combined, the witness cited the analogy of the staff of the army in India, in which half the appointments are reserved for officers of the British service, who came out to India for limited tours. He suggested that, in the same way, they should indent from home for so many officers from the Royal Army Medical Corps, so many major-generals, lieutenant-colonels, etc. In that way the higher appointments would be equalized between the two services. He would not be inclined to second Royal Army Medical Corps officers for the Indian Army Medical Service for the time they were out in India. He did not think that that would be either necessary or popular.

His proposals with regard to promotion were made with a view to bringing the principles as much as possible into line with those which obtained in the Indian Army, which are nearly the same as those for the Royal Army Medical Corps.

The pay for the two services would be identical, but officers in the Indian Army Medical Corps would receive special rates of furlough pay and pension for permanent service and allowances conditional on passing and keeping up certain language tests.

He did not think that they could refuse to allow Indians into the Indian Army Medical Corps, since they are admitted into other parts of the Indian Army.

He was not in favour of a unified military medical service, if by that was meant the incorporation of the Royal Army Medical Corps into the Indian Medical Service. He did not think it was necessary. It was now quite sufficiently unified for military purposes, in the same way as the rest of the army in India.

In regard to the question of imposing liability for military service on officers of the civil medical service, that was also a corollary to the present Indian Defence Force Act, which contemplated service to the State in the case of every European. It might mean a little further extension in the case of Indians for service with the Indian Army Medical Corps.

With reference to the question of permitting officers of the Indian Army Medical Corps to serve in civil appointments beyond a strictly limited number of years, he would only recommend this on the understanding that they did not come back to the army.

In regard to scheme 'A,' the witness was not prepared to answer the question as to whether, in point of numbers, the scheme would afford a sufficient military medical service in this country. It was just a question of fixing proportions.

The great drawback to that scheme, from the point of view of India, was the political one. He fancied that the Royal Army Medical Corps was not prepared to go back on their charter. Their service was reserved for men of pure European extraction. This would be contrary to the rest of the Indian Army which had opened its doors without reservation as to colour.

In regard to the question whether the auxiliary corps that was contemplated would give sufficient opening for Indians and Anglo-Indians to satisfy their desire to enter military service, the witness was certain that Indians would not think so. They would regard it as a profession from which they were barred.

He did not greatly believe in the idea of periodically reverting officers from civil medical employ to military duty for training.

The witness thought that the scheme failed in not providing a military career for Indians and Anglo-Indians, and that, so far as conditions went at present, it was an almost insuperable drawback. The fact that the auxiliary corps would be called the Royal Army Medical Corps would not be a sufficient attraction.

As regards the question whether an Indian belonging to the Indian Army Medical Corps would command a station hospital in this country, in which both Royal Army Medical Corps officers and rank and file would serve, or, in other words, where British officers and rank and file would be serving under the command of an Indian or Anglo-Indian, the witness said that it was absolutely unavoidable. He had no doubt that they would try to make arrangements that such a state of affairs should not occur, but the Indian had an absolute right to such a command in virtue of his commission, and the witness did not think he could be barred from it. He thought that, if they had a civilian medical service, as well as an Indian Army Medical Service, they would find that most of the Indians would gravitate towards the civil medical service.

In reply to a question as to whether he had read Sir Reginald Craddock's scheme, the witness replied in the negative. On being handed the document for perusal, the witness said that he could see Sir Reginald Craddock's point. It was a difficult one, namely, the treatment of Europeans by Asiatics, and, of course, one had to defer to his opinion. He (the witness) could not guarantee that it would be accepted by Indians in the spirit that it should be.

In regard to the danger that a local military medical service might become Indianized, the witness said that they were providing for it in the case of the army by limiting the number of Indians who could obtain commissions. There was no limit at present fixed for the Indian Medical Service; but he was not at all sure that Indians would come into a purely military service. There was, however, always the danger of such a contingency.

In reply to a question as to the advantages of having one imperial medical service for the whole army, the witness stated that that raised a very large question indeed, namely, whether they were going to have an imperial army or not. The whole question was under consideration, but as long as they had a local army, namely, the Indian Army, the Government of India claimed to have a great say in its administration in every way. As things are at present, he did not think they could have a particular corps of that army on imperial lines, unless the rest of it was.

(General Hehir.) He saw no reason against the present Indian Medical Service being converted into an Indian Medical Corps officered by the present Indian Medical Service, members of the present Indian Medical Department being incorporated into it, with the proposed Indian Hospital Corps forming its rank and file.

In regard to the formation of a war reserve of medical officers for the army in India, the witness said that every European doctor in India would be a member of the Indian Defence Force, and thus liable for military service. They would be of great use in station and general hospitals, setting free regular officers for other duties on mobilisation.

With regard to the question of maintaining a reserve of medical men, in the United Kingdom, selected and maintained by the Secretary of State for India, to supplement that in India, it would be impossible to say whether it would be a feasible proposition. It would also be impossible to guarantee that they would reach India in time when wanted.

The witness agreed that scheme 'C' was very much like his own, except that he would not second Royal

11 February 1919.]

Lieutenant-General Sir H. HUDSON.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

Army Medical Corps officers to the Indian Medical Service. He would bring them out for periods of service, as they stood less chance of conflicting interests that way, because one ensured that the number that came out were fixed up for certain definite occupation. If they were merely seconded, there would be the danger of either one side or the other filling up the higher appointments.

The witness considered that the idea of permitting officers of the Indian Army Medical Corps to be seconded for service in civil would be excellent, provided the term was limited to, say 5 years.

He knew of very few cases where Indian officers had attended the families of British officers in India.

(General Hendley.) The present defect in the Indian Medical Service, from the military point of view, could not be remedied so long as the present system, by which men could divest themselves of the military part of their career, for a number of years, was in vogue. His proposals would, he thought, remedy the defect.

The total requirements of medical officers for general mobilization could not be maintained in the army in peace time. The additional requirements would have to be met by expansion. That expansion would either have to come from the civil medical service in India or from outside. It would mean keeping up a very large reserve in the civil department, or doubling up the work in the civil department. Theoretically, the number of troops in India, after the expeditionary force had gone out, would be small; in practice, in this war, it was very much larger than it had been in peace.

In selecting Indian officers, he would recommend a selection board before they were allowed to present themselves for examination. In the case of candidates for Kings commissions in the Indian Army, the local government nominates its candidates; they then come before the board. It would be a little different in the case of the medical services. A man had a long course of 5 years at the schools, and it was hard to lay down that before he attended any medical school he would have to be passed by the board.

He would approve of a plan to give scholarships to Indian students who had completed 3 years' medical study in India; the scholarship to be granted after the candidate had passed a suitable examination, and had been approved by the selection board. This might result in a better class of men being obtained for the service.

The provision of a military medical college in India would help considerably to make the Indian Medical Service a really efficient service from the military point of view, supposing that the Indian Medical Service was to remain as a service.

(General Giffard.) With regard to the point whether it was desirable that there should be a unified medical service for India, he considered that the scheme which he (the witness) had sketched was a unified military medical service, because the whole service was administered by one officer, namely, the Commander-in-Chief.

He was against a unified military and civil, that is to say an amalgamated, service, for the reasons that he had given in his note. He thought that it was necessary that a medical officer should stay continuously in the army. Conditions were altering every day, so that it was necessary to keep abreast of the times.

It was submitted to the witness that, supposing the civil department became an absolutely separate one, except for the training, it would almost certainly mean one of two things: either that the civil department would become unpopular with the profession because better posts would be held on the army side; or, secondly, that Indians would find themselves cut off from administrative appointments in the army. The witness thought that a very difficult question. He would say, however, that the present amalgamated system was not a success. He had not noticed that the existence of two services led to constant friction. One objection to a unified service would be the question as to whom it would be under. It was very difficult, from the military point of view, to have a military department under another department altogether. They had had trouble

already, and there was a possible element of trouble between the Army and the Home Departments.

The advantage of scheme 'A' over the present Indian Medical Service, even if properly trained and prevented from engaging in long periods of civil employ would be that the interests of the Royal Army Medical Corps would be sufficiently safeguarded. There must be a proportion of the Royal Army Medical Corps out in India, as you could not get on without them. Although many people thought it better to have one medical service for the whole of the army business of the Government of India, the witness thought that the great value which was got out here of having access to the latest European ideas was lost sight of.

In regard to the suggestion that, if the present sort of Indian Medical Service were cut off from civil employ, the civil would become more entirely Indian, which would be hard on the European members of government services, he thought that many European doctors would come to India for employment on 5 years' contracts. In the Public Works Department they came out for short periods, and in the same way if they had a big hospital in Calcutta, they would get thoroughly trained men from home to organise it, making it a 5 years' job. He thought there would be a large number who would come out, especially if they were going to nationalize the medical services at home. All that need be done, as regards the civil, was to make the terms sufficiently attractive to get out the best men.

In reply to the question as to how the civil service, partly trained to military work, would differ from the auxiliary military service more trained to military work, and what the army would gain by that, the witness stated that it was necessary to have a separate civil service in India. Men would not come out to India unless they were given high posts, and if this were not done, the Indian would certainly take the posts.

The witness admitted that the Indian officer with a King's commission had come to stay, and that scheme 'A' would cut him out altogether from any commission in the medical service.

The danger of having an amalgamated civil and military service lies in the fact that, although it may be arranged that officers in civil employ revert for military training at stated intervals, yet, in actual practice, this arrangement cannot in many instances be carried out, as local governments, etc., may represent that it is impossible to surrender an officer when the time comes for his reversion.

Asked whether it was possible for a medical man employed continuously in military service and treated as a soldier to keep up his medical knowledge, the witness replied that that was provided for to a certain extent in the case of a large number of the junior ranks. The senior officers in a station hospital did not do clinical work.

(Mr. Hignell.) He had carefully considered this question of a unified civil and military service and had come to the conclusion that it was undesirable. The war had confirmed that impression. Most of the schemes that had been put before him had the same general principles underlying them, namely, that a unified service was not possible. He did not think that the working out of details for his scheme was a matter of difficulty, so long as you accepted the basic principles.

In reply to a question as to whether he considered it desirable to have an imperial medical service, he said that that must follow entirely on the general policy of the Government as to whether there was to be an imperial army. That, of course, might mean the inclusion of Indians; it might mean that the Royal Army Medical Corps would have to alter their charter, so as to include any British subject. If there is to be an imperial army in the future, it would be reasonable to have an imperial military medical service. The witness agreed that if you had a corps like the Royal Army Medical Corps, it would be rather anomalous not to utilise it in the case of India but to substitute for it a local service; and that, therefore, the absorption of

11 February 1919.]

Lieutenant-General Sir H. HUDSON.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

the Royal Army Medical Corps by the Indian Medical Service, as it stood, would be undesirable.

In regard to the question whether, from the point of view of the army, it was necessary that a military medical man should have any very close knowledge of women's and children's diseases, he said that the first principle of the Royal Army Medical Corps was the prevention of disease, so as to have as little sickness as possible to treat. The care of women and children came purely from economical reasons. The chief object of the military medical service was to keep the men fit, and, when they were wounded and sick, to cure them as quickly as possible. Proceeding out of this point, the question of general training for the medical military service arose, and was met by the fact that they had specialists in every division; there were specialists in dermatology, ophthalmology, etc., and that would continue. With the development of the hospital system on big lines, he believed it was contemplated having divisional hospitals which would take special cases and be looked after by specialists.

In reply to a question as to the military population that the medical service would treat, in peace time,

the witness said that, putting it in outside figures, it would be about 75,000 British and 250,000 Indians.

In regard to the proportion of officers of the Indian Army Medical Corps, who should be permitted to serve in civil employment, he would not fix any proportion; it depended on the number one wished to employ. It was possible that, if there were a large increase in civil prospects, many valuable officers might be lost to the army, but that risk must be faced. It would be a matter of adjustment between the Home and Army Departments, and would have to be regulated by the Secretary of State. He would allow for a proportion to remain in civil employ for a period not exceeding 5 years, and they must decide during the first ten years of their service whether they would remain in civil employ. The latest he would allow a man to go into civil would be on reaching the rank of lieutenant-colonel.

The proportion of Indians he would contemplate in the Indian Army Medical Corps, as a maximum, would perhaps be 10 per cent. It was a very difficult question to raise because they had up to the present put no limit on them at all, and to introduce a limit, where there had previously been none, would be very difficult.

DR. (MISS) K. A. PLATT, M.D., B.S., Women's Medical Service, Principal, Lady Hardinge Medical College.

Written Statement regarding the position of medical women in India.

Having no special knowledge of the constitution and administration of the Royal Army Medical Corps and Indian Medical Service, I cannot venture to give any opinion on the relative advantages and disadvantages of the four schemes suggested for their reorganization.

As a result, however, of ten years' medical work amongst both European and Indian women and children in various parts of India, I feel sure that the establishment of some civil medical service in which women practitioners are included is necessary. As far as I can judge, scheme 'C,' with some modifications, is a very practical one. I would suggest that if some such scheme were adopted and medical women enrolled as members, their services might be utilized in war time to replace those medical men called to military service, though of course, should necessity arise, they might be used to staff military base hospitals.

The present Women's Medical Service, if extended and the conditions of service made more satisfactory, might serve as a nucleus of a women's department

of a civil medical service. The qualifications of the large majority of the Women's Medical Service are such as would qualify them to become members of such a service. Recruiting might be by open competition. Successful candidates should be required to spend six months in a school of tropical medicine, and should for the first two or three years of their service be on the staff of one of the larger women's hospitals. They might, further, be required to spend a period of six months every five years in a civil general or military hospital.

The demand of Europeans for European medical attendance for themselves and families is, I consider, largely based on racial predilection. In the very large majority of cases, European women have the greatest objection to be attended by an Indian medical man, whatever his qualifications, with a few notable exceptions of Indians who have specialized in certain directions. The ordinary Indian medical practitioner, even though he may possess a European qualification, is rarely called on to attend European women.

DR. K. A. PLATT, called and examined.

(President.) She had been in India for the last 10 years, in Bombay, Poona, Calcutta and Delhi. She was now principal of the Lady Hardinge Women's College and Hospital, Delhi. She came out to India independently, and joined the Women's Medical Service when it was first formed, in 1914.

Most of her work had been amongst Indians, but she had always had, in addition, a considerable practice amongst Europeans.

There was an increasing tendency among Indian women both to turn to western medicine for themselves, and also to take it up as a profession.

Out of a total of 60 women students at the Lady Hardinge Medical College and Hospital, 30 were Anglo-Indians, 5 Europeans, and the remainder Indians.

The majority of the students aimed at taking the M. B., B. S. degree of the Lahore University, which was registered as a colonial degree in Great Britain. After qualifying they took up work as house surgeons in various women's hospitals. Then they were put in charge of small independent hospitals, while some of them went to England to obtain a British qualification. In her opinion it was unnecessary for them to take a European qualification.

Applications for admission to the college were increasing, and in excess of vacancies.

(General Cree.) She thought that if, and when, a new civil medical service was organized, women doctors should certainly have a place in it. Women's hospitals in India should be staffed by medical women.

(General Hehir.) Indian women doctors might advantageously be employed to treat the wives and children of Indian soldiers, and she saw nothing impossible in the idea of their also treating the soldiers themselves. Even in surgical and medical work Indian men were quite amenable to treatment by women doctors.

It would be feasible to form a war reserve of Anglo-Indian and Indian nurses, but they should always be under European supervision. The class of Indian women that became nurses could not be trusted to work independently—largely on moral grounds.

(General Hendley.) There was a very large demand for women doctors, chiefly from public bodies, such as municipalities and district boards. These demands were greater than the supply, at present. The conditions of service of women doctors under some of these bodies were unsatisfactory in many ways. The hospitals in which they had to work were also often very inadequately equipped.

She was in favour of a separate service for women doctors working under public bodies. Such a service should be controlled by Government, appointments and transfers being arranged by some central authority.

11 February 1919.]

Dr. K. A. PLATT.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

She considered the scheme of forming a service of women assistant and sub-assistant surgeons very sound. Such a scheme had not progressed beyond the stage of consideration, except in the United Provinces.

Regular inspection of all hospitals staffed by women doctors was essential, but was only carried out at present in a very few places.

Post-graduate training was most necessary. Her experience was that most Indian women doctors deteriorated very markedly after they had been qualified for five years, unless they received such training.

It was not impossible that at some future date Indian women doctors would be able satisfactorily to undertake the treatment of European women and children.

(General Giffard.) Medical women in India might very well help to form a reserve for the army. She considered that they would be more usefully employed in relieving civil surgeons and thereby setting them free for military duty, than in staffing military hospitals, as they had done at Bombay and Secunderabad during the recent war. Indian women were not likely to be of much use in this respect for some time to come.

(Mr. Hignell.) The work done in India by medical women had greatly expanded of late, and was still expanding. If a satisfactory women's medical service was organized, with good attractions, more European women doctors would probably come out to India. At present the pay and prospects were not sufficient to induce any European women to come out to practice independently.

14 February 1919.]

Lieutenant-Colonel R. A. NEEDHAM.

*(The schemes and questions referred to by witnesses are contained in Volume III.)***At Delhi, Friday, 14th February 1919.**

PRESENT:

THE HON'BLE SIR VERNEY LOVETT, K.C.S.I., I.C.S. (*President*).

MAJOR-GENERAL G. CREE, C.B., C.M.G., A.M.S.

MAJOR-GENERAL P. HEHIR, C.B., C.M.G., C.I.E.,
I.M.S.

MAJOR-GENERAL H. HENDLEY, K.H.S., I.M.S.

THE HON'BLE MAJOR-GENERAL G. G. GIFFARD,
C.S.I., I.M.S.

S. R. HIGNELL, Esq., C.I.E., I.C.S.

LIEUTENANT-COLONEL A. SHAIRP, C.M.G., Indian
Army.

LIEUTENANT-COLONEL G. B. A. RIND, Indian Army.

MAJOR A. A. MCNEIGHT, I.M.S. (*Secretary*).

LIEUTENANT-COLONEL R. A. NEEDHAM, D.S.O., I.M.S., Deputy Director-General, Indian Medical Service.

Written statement.

(1) Any scheme for organising the military medical services in India must assume the continuance of the grant of commissions to Indians.

(2) A unified military medical service is desirable.

(3) The Royal Army Medical Corps cannot be the basis of a unified service unless it admits Indians.

(4) The Indian Medical Service cannot be the basis of a unified service unless it replaces the Royal Army Medical Corps in India.

(5) A purely military medical service for the Indian Army to which Indians are freely admitted will not obtain European recruits unless it offers special attractions.

(6) Such attractions lie mainly in the alternative opportunities offered in the transfer to civil employment.

(7) The withdrawal or curtailment of such opportunities will result in a purely military medical service for the Indian Army becoming mainly if not entirely Indian.

(8) A purely civil medical service independently recruited will in all probability be organised on a provincial basis; European officers who could be recruited for it would be for the highly paid indispensable posts, and probably not available as a war reserve. Nor would such officers elect to serve under officers of a purely military Indian Medical Service composed chiefly of Indians.

(9) Military doctors should be in close touch with civil doctors. They should be doctors as well as soldiers, and most especially so in the East. Complete severance of military and civil doctors is detrimental to both services. Specialisation in military medical matters and administration is not incompatible with professional skill or with civil employ.

(10) The civil medical departments should not be merely adjuncts of the military service. This can never be the case if the civil medical requirements of India are adequately met. The war reserve of the military service employed in civil duties would be only a small part of the number of doctors necessary, if these requirements are met. The growth of medical colleges, schools, research institutes and sanitary services will result in the civil needs far outstanding the army needs.

(11) Increased opportunities are needed for Indians of high qualifications and good standing to enter the service. Scholarships after passing the Intermediate M. B. examination (3rd year) should be awarded after nomination by the principals of the medical colleges in India, and be tenable for two years in England. If an examination is instituted, marks should not be the only consideration. Scholarship holders should be physically fit and suitable in every way for a commission in the Indian Medical Service. There should

be no obligation whatsoever for them to compete for the Indian Medical Service. The absolute freedom of such scholarship holders to compete for the service or not is a very important point.

I have purposely confined myself in the above paragraphs to fundamental points.

I have stated that in my opinion a unified medical service is desirable. The reasons are given in the memorandum ⁽¹⁾ referred to in my letter ⁽²⁾. From the history, however, of all previous attempts put forward during the last 50 years which involved any form of unification of the Royal Army Medical Corps and Indian Medical Service, and from a knowledge of the obstacles still existing I am frankly sceptical as to the chances of any scheme for unification being carried through now. In any case prolonged discussion and delay is inevitable. If a complete breakdown of the Indian Medical Service is to be avoided, steps should be taken at once for its reform. These steps can be undertaken without further delay and I would respectfully suggest that the Committee should make recommendations to avoid such a breakdown, if necessary, independently of their final report. Much can be done: vast improvements are possible in the Indian Medical Service without any question of unification arising. These steps should, however, be in the direction of bringing the rules and regulations governing the Royal Army Medical Corps and Indian Medical Service more into line and approximating the conditions of service. This would in no way interfere with unification at a later date, if found desirable. For example:—

(a) *Dates of competitive entrance examination.*—This should be the same in both services and the examination should commence on the same date. I would maintain separate examinations at present in order to avoid the jealousies which arise when there is a particular preference for one service and all the top candidates select that service leaving candidates with low marks to join the other service.

(b) *Commissions of successful candidates* should be dated on the same day.

(c) *Promotion to captains.*—This should be after three years in each service. At present it is three and half years in the Royal Army Medical Corps and three years in the Indian Medical Service.

(d) *Promotion to major.*—It should be after 12 years total service in both cases.

(e) *Accelerated promotion.*—The rules governing accelerated promotion should be revised and brought into line, one service with the other. I would abolish the system of granting three to 18 months accelerated promotion in the Royal Army Medical Corps after study at Millbank, and also abolish the grant of six months accelerated promotion given after an approved

¹ See Volume III, page 42.² Not reproduced.

14 February 1919.]

Lieutenant-Colonel R. A. NEEDHAM.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

course of study in the Indian Medical Service. In the Indian Medical Service the rules governing accelerated promotion have broken down because of the war, during which no officer could obtain study leave. I suggest that we should institute a course of study at the Indian "Millbank" College (to be established) or at a Tropical School of Medicine in India, comparable to that now in force at Millbank. Royal Army Medical Corps and Indian Medical Service officers should be eligible to take the course prescribed either in London or in India according to administrative convenience or by selection or by application of individual. Merit should be rewarded and the reward in both services should be strictly comparable, and depend on each candidate's whole record, not only the marks he received at any examination. A system of granting brevet rank as a reward is suggested. The brevet might carry pay. The main point is that the reward should not involve the hardship of permanent supersession of deserving officers.

(f) *The examination for promotion to major and for promotion to lieutenant-colonel* should be the same in both services. Promotion to lieutenant-colonel in the British Army Medical Service is on the occurrence of a vacancy, while in the Indian Army promotion is on a time scale. Inequalities are consequently inevitable. Sometimes the Royal Army Medical Corps officers are

promoted to the rank of lieutenant-colonels at 23 years as before the war and sometimes at 16 and a half years as in 1915. The Indian Medical Service promotion remains stationary at 20 years. I would suggest therefore the adoption of the Royal Army Medical Corps system of promotion by selection on the occurrence of a vacancy. This is, at all events, a step towards equalising the flow of promotion, though it can never be made the same unless officers are borne on one list.

Further examples of improvements are given in Part II of the memorandum for improving the military and civil sides of the Indian Medical Service and I need not repeat them here.

In my opinion it is urgently necessary to bring to the notice of the medical profession in as public a manner as possible the fact that the conditions of pay and service of the Indian Medical Service are being considered and improved.

I have omitted in this note any reference to—

- (1) Medical education,
- (2) Assistant surgeons, and
- (3) Sub-assistant surgeons.

I am prepared, however, to give such evidence as the Committee may require on these subjects.

LIEUTENANT-COLONEL R. A. NEEDHAM, called and examined.

(President.) The witness had had 16 years service in all; 10 in military and six in civil. The first eight years he spent in military employ and three as Health Officer, Simla. He was on active service in France for two years.

He was in favour of a unified service for India—a military service with its reserve in civil—to which Royal Army Medical Corps officers should be seconded or transferred. It should also include officers recruited from home. There might also be provision for the promotion of military assistant surgeons to this service. Officers recruited from home should go through a special course of six months' training in a central college which should be established in India and after that they would be drafted to military duty. The period spent in military duty would depend on vacancies occurring in civil employ, but it should not be less than two, nor more than seven years. Transfer to civil employ should be voluntary. While in civil employ officers should be liable to recall for military duty when required, up to 20 years' service, after which they should be made to elect for permanent civil duty or returned to military.

The medical charge of British regiments would normally be held by Royal Army Medical Corps officers serving in India but he would not debar Indians from holding these charges.

He refused to contemplate the possibility of the complete Indianization of the future medical service. This would only come when India was handed over entirely to the Indians.

(General Cree.) The Medical Service for India should be a unified service, and the civil side should not be separate from the military.

In his opinion scheme 'A' did not provide a career for Indians. Even if the rules for the auxiliary corps contained provision for promotion to the highest grades it would still be an inferior service, and would be looked upon as such and could not satisfy the aspirations of Indians.

He did not contemplate the exclusion of the Royal Army Medical Corps from India as the Royal Army Medical Corps would always send out officers to be seconded to the new service. Seconded Royal Army Medical Corps officers should hold the same rank as they did now. The only difference would be that they would be serving under the Indian Government. This would obviate the formation of a separate corps in India and the officers so seconded would be under the administration of the new service.

He would not say that the Director of Medical Service in India should always be an Indian Medical Service officer, but generally he should be. There would be no objection to placing Royal Army Medical Corps officers under an Indian Medical Service officer just as at present Indian Medical Service officers are serving under a Director of Medical Services belonging to the British Service.

With regard to the separation of the military from the civil medical service witness was of opinion that an independent military service would not offer sufficient attraction to candidates and ultimately few Europeans would join it.

Officers did not enter the present Indian Medical Service with the sole idea of obtaining civil employment, although the prospect of such employment was one of the main attractions of the service. While a young officer had the opportunity of a military career he also had an opportunity of a civil career with increased emoluments as he advanced in service. If the attraction of civil employ was taken away there would be a danger of the service becoming Indianized, as few Europeans would enter it.

With regard to the necessity of Indian Medical Service officers in civil employ maintaining their knowledge of military administration, he remarked that as such officers had done five to seven years military service already, it would be sufficient in order to fit them for a "first reserve," if after promotion to the rank of major they underwent a short annual period of military training. After 20 years service they would be either permanently in civil or permanently in military employ.

He did not think that the whole of the civil requirements of India should be met from the Indian Medical Service. The civil side of the service would expand greatly and should be recruited from other sources also.

(General Hehir.) He was of opinion that some announcement should be made as early as possible to the effect that improvements are being carried out in the Indian Medical Service and considered that this was vital to the continuance of the service.

The post of Director of Medical Services should be filled by the best qualified officer available for it, whether he belonged to the British or Indian service.

He was in favour of examination before promotion from captain to major and from major to lieutenant-colonel, and also of promotion from major to lieutenant-colonel being made by selection, as is done in the Royal Army Medical Corps. He was in favour of the selected list of lieutenant-colonels being abolished pro-

14 February 1919.]

Lieutenant-Colonel R. A. NEEDHAM.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

vided the monetary interests of officers were safeguarded.

He strongly advocated the opening of a military medical college for the military and professional training of Indian Medical Service officers.

He was in favour of an advisory committee to select officers for appointments to civil administrative posts, but its functions should be limited to this.

(Colonel Rind.) He would let an Indian Medical Service officer stay in civil employ up to 20 years service, and he would not fear that such an officer on returning, in time of war, to military employment would hold a high administrative post, because the authorities would see that he was not appointed to it. Such officers would have had their annual military training, and therefore would not be necessarily inefficient from the military point of view.

(General Hendley.) He would give officers the option of electing either for permanent civil or military, up to 20 years' service. The lower the age was fixed at which selection should be made the fewer officers there would be in the reserve.

The rules for promotion in the Indian Medical Service should be assimilated to those in the Royal Army Medical Corps because the present differences in the rules had resulted in discontent.

He was in favour of granting scholarships for study in Europe to Indian and Anglo-Indian medical students after three years' study in India. But he would not make the grant of a scholarship conditional on an undertaking to ultimately compete for the medical service.

(Mr. Hignell.) Scheme 'A' would be suitable if it was modified to meet the political aspirations of Indians and employed a reserve in a civil capacity. Scheme 'D' met these aspirations as far as the military side was concerned. It was important that in either scheme a percentage of the military service should be employed on civil duties.

The present discontent in the Indian Medical Service, dated from 1907 or 1909.

Whatever scheme was adopted there should be a military medical college in India. There should also be a large war reserve and adequate provision should be made for study leave.

The number of Indian Medical Service officers reverted from civil to military employ during the last war was roughly 360. Since the armistice was signed local governments had pressed for the return of these officers but during the last three months only 26 officers had been returned altogether. He did not think that the civil medical needs of the country had been subordinated to military needs in peace time.

(General Giffard.) He did not favour the establishment of a universal medical service, comprising all the departments, such as civil, military, research, etc. He was in favour of a unified military medical service with a reserve employed in civil. Purely civil needs could be met by expansion, to any extent, of provincial services or by employing independent medical men according to conditions as they arose. A special reserve could be organized from such men. At the present time about one-third of the total strength of Indian Medical Service officers are in military and two-thirds in civil employ. A civil service recruited in England might give satisfaction, but probably recruits could be obtained there only for the higher posts.

He did not think that the formation of a unified service would in course of time exclude the Royal Army Medical Corps joining it as seconded officers; at any rate he would not like to see it.

(President.) The reason why Indian temporary Indian Medical Service officers recruited during the recent war had not proved satisfactory was that they were unfamiliar with military conditions and were probably associating with Europeans for the first time, and their surroundings were therefore unfavourable. There were about seven or eight officers of the regular Indian Medical Service in France. Some of these have done very well.

LIEUTENANT-COLONEL H. AUSTEN SMITH, C.I.E., I.M.S., Surgeon to His Excellency the Viceroy.

Written statement.

Having the two services, the Royal Army Medical Corps and the Indian Medical Service, working side by side in India, in my opinion, leads to a want of economy in personnel and a lack of efficiency in administration from the dual control. Considering the divided interests of the two services it seems to me that it must be so and that there must be a duplication of labour. The scheme that suggests itself to me as remedying existing defects is the establishment of a unified medical service for India, styled the Indian Medical Corps, combining most advantageously the two services in India into one, this service to take over medical charge of all troops in India, both British and Indian, its war reserve being employed in times of peace on civil duty. Such a service would have a life long interest in the country, and would be alive to the necessities of India from the view of the needs of medical administration as they arise.

Regarding the schemes which have been put forward as remedying the existing defects, scheme 'A' would in my opinion never work satisfactorily. It does not present a unified medical service, but two services, (i) the Royal Army Medical Corps, and (ii) the auxiliary corps, which is the present Indian Medical Service. It would tend to make the position more difficult than it is now and I am quite certain that no Indian educated in medical schools in England and with English degrees, would ever think of entering the auxiliary corps, which would in time tend to take a subordinate position. Indians cannot, by regulation, be admitted to the Royal Army Medical Corps, and they must be admitted to the unified medical service. The new unified medical service must be such as to take into consideration the advantages of both services, mould them into one, and it must meet the demands and aspirations of Indians if

it is to be acceptable to India. I personally favour the schemes laid down in 'B,' 'C' and 'D' which are all fundamentally the same though discussed much more fully in 'C.' I think such a scheme presents a satisfactory and workable foundation and I think it is possible from them to form a sound scheme for a unified Indian Medical Service or Corps. There are many points in the formation of the unified medical service which require very careful consideration and the most important is the condition under which officers of the Royal Army Medical Corps would join the new service.

The scheme for the formation of a unified medical service such as is discussed more fully in 'C' would I think commend itself to the War Office provided they approved of two points:—

- (1) The consideration under which officers of the Royal Army Medical Corps are to join the new service
- (2) That the needs of the British Army in India are thoroughly considered.

To make such a scheme succeed and meet the approval of the War Office it would be necessary at once to take into the service a certain number of officers of the Royal Army Medical Corps of various ranks. For the future, junior officers of the Royal Army Medical Corps should be eligible for permanent transfer to the Indian Medical Corps and other officers could volunteer for terms of duty with the army in India. This is discussed thoroughly in scheme 'C' and with the view expressed there I agree. At the same time, while making the service favourable for the admission of officers of the Royal Army Medical Corps, it would be necessary to safeguard the interests of the existing officers of the Indian Medical Service. These officers have

14 February 1919.]

Lieutenant-Colonel H. AUSTEN SMITH.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

suffered in promotion in this war and this, taken in comparison with the quicker promotion of officers of the Royal Army Medical Corps, would need to be remedied.

I feel that such a unified service can be formed and think it would have a great future considering the immensity of the general medical needs of India as a whole.

I consider that such a scheme as outlined above and thoroughly discussed in 'C' should attract a good stamp of recruit and that it would meet the demands of professional opinion in England provided:—

- (1) The pay of the service was adequate, and for this to be so there would need to be a very material increase on the present rates of pay of the Indian Medical Service.
- (2) The opportunities for taking leave were more liberal than they are now. For this there must be an adequate leave reserve.
- (3) That the heads of the service, assisted by Boards of Control, had a more direct access to the heads of Government in the discussion of medical matters in India.

As I have said above, the medical administration of India will loom large in the future for the following reasons:—

- (1) The need for better hospitals, and better medical organisations generally, for the army in India, both British and Indian. The need for this has been proved over and over again in the present war.
- (2) Medical research, which is most important both for the army and the civil population of India. The field for medical research in India is immense and its results may be of benefit to all tropical countries.
- (3) The large questions of public health.—These again affect both the army and civil population and are of the greatest importance.

I think with a unified service—the military and civil sides of it working hand in hand—adequately paid, able to get regular leave, both for purposes of health and study, holding a good position with the Government of the country, that a good stamp of recruit would join and that the service would be a good one.

The importance of an efficient European element in the new service cannot be over estimated, affecting, as it does, not only the army, but the whole of the European services in India.

There is no doubt in my opinion, and I am here speaking confidentially, that the result of withdrawing European medical officers from the charge of troops, civil districts and jails in India, has led to some inefficiency in administration. I do not say this with any view of underestimating the powers of Indians, but this administration had in most cases to be taken over by Indian assistant surgeons, many of them nearing retirement and lacking in energy. Here I think the evidence of inspectors-general of civil hospitals of the several provinces will be of value, as they have personally seen the results of having suddenly to withdraw the majority of officers of the Indian Medical Service in civil employ from the civil medical charge of districts, jails, etc.

As regards the medical charge of troops, I have while in command of a very large Indian general hospital (No. 1, Indian General Hospital) during two years of the war, had quite a number of temporary officers (Indian) of the Indian Medical Service serving under me. A few of the best type, with the highest qualifications did very well indeed, but the majority, coming from the assistant surgeon class, did not impress me.

This proves the necessity of making the new service such as to attract the best type of Indian, every one of whom should possess English qualifications, and this should be made a definite condition of entry to the service.

The scheme I recommend to meet the medical needs of the civil administration of India, is to have a civil medical service, which should in my opinion be as, it

is at present, a civil side of the new unified medical service as far as the officers of the service are concerned.

Officers would be seconded to civil appointments, but reverting to the military side of the service for a period of military training every five or seven years. There would be a certain number of indispensable appointments from which officers could be recalled for military duty. Some of the higher and more important appointments could be recruited straight from home for periods of years, so as to get the very best officers possible. Officers from the Research and Public Health Departments would be of great value to an army in the field, in fact, as specialists they would be indispensable. It would be necessary, so as not to dislocate the civil medical needs of a province, research or public health work, to make many appointments indispensable, and these would be the senior posts, and during war on a large scale to withdraw the more junior officers, whose posts could be more easily filled by officials working under them, presumably trained Indians. In this way there would not be such a sudden dislocation of civil medical work as there was in this war.

The scheme of a civil medical service working hand in hand with the new unified medical service, and being officered by this service to a large extent, would form a very efficient reserve for military purposes; the officers would by periods of reversion to military duty be kept up to date in military medical work, and quickly fall into their places. In fact, I would have units for war purposes, field ambulances, general hospitals, etc., fully arranged for on paper; the place of assembling detailed where all the equipment, etc., would be ready, and all the officers and staff would have their orders where to join, etc. The officer commanding would be from the military side, and the staff picked from suitable officers of the military and civil services. In this way he would at once have a staff trained to their special duties, and not officers placed in unsuitable appointments as occurred very often in the war. In addition, the civil medical practitioner should be made use of as a war reserve. A list should be kept and these practitioners detailed for suitable war appointments. This reserve should go through regular periods of training, and this should be at the staff college of the Indian Medical Corps, which will be a very necessary adjunct of the new administration. Indian assistant surgeons could also form a war reserve up to a certain age, and these too would need to undergo regular periods of military training.

I think that the medical service reserve should be previously trained in military work, and from my experience in this war, I think this is very necessary indeed. If medical men, especially Indians, are not trained, they are for a period more or less useless, as it is necessary to train them for their duties which are quite new to them and to which it takes time to get accustomed. This war reserve need not be always actually present in India, and it would be quite possible to have in England a war reserve of specialists, a few expert specialists being on the war reserve list to be called out if necessary. Some officers of the war reserve might be at home on leave but they could be quickly recalled when necessary. The bulk of the reserve for military purposes would naturally need to be in India.

The Indian Medical Service reserve (civil side) has proved of great value in this war, as it enabled field medical units to be sent off at once, and to consist of officers trained in military duties, although had better previous arrangements been made, more suitable officers might have been selected for special appointments.

By insisting on officers undergoing regular periods of military training it will be known what are the most suitable appointments for them. Three-quarters of the officers on the civil side of the Indian Medical Service were recalled to military duty during the first year of the war. Without this war reserve of the Indian Medical Service I do not know how the medical work of the Indian Army could have been carried on, whereas, as things were, the officers have been a great success in this war; the failure was chiefly in equipment and the policy of not looking ahead and being prepared.

14 February 1919.]

Lieutenant-Colonel H. AUSTEN SMITH.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

Recruitment should always be by examination and these examinations should always be held in England. English qualification should always be necessary as a definite condition of entering for this service. This will make it necessary that officers should always be either entirely or partially educated in England. This I consider is most important for the future efficiency of the service and I would allow no departure from this rule.

I consider that the grant of special leave for study is a necessity and any departure from the present rule of granting an officer study leave for a year during his service would be retrograde.

A keen medical man will always keep up to date; it is absolutely necessary for him to do so to be successful, but he will not probably go in for regular hard periods of study such as is necessary during study leave, and it is only right that he should be given the extra allowances during study leave to cover the cost of hospital fees, classes, etc. I would also advocate in special cases officers for very special appointments being deputed to England or Europe for special study and experience.

There are in India many government civil hospitals with much clinical material, and this is not made use of; much useful experience could be gained at large civil hospitals and help would be gratefully accepted. There is in this way a waste of much good clinical material. Post-graduate classes could be held at the various medical colleges in India, in medicine, surgery, bacteriology, and pathology, eye diseases, etc., which would be of great value to medical officers.

Soon the schools for tropical diseases will be opened in Calcutta and Bombay and the experience in tropical diseases to be gained in these will be second to none in the world. Every officer on entry to the service should be required to go through a course at the military medical staff college and one of the schools of tropical diseases, which will include a course of public health special to India.

I consider a special department for research to be an urgent necessity. There is a large field for research work in India and by its results it will prove of inestimable value to India. Many diseases attack labour, e.g., hookworm. By research work these diseases can be worked out, and when the life history of the bacillus and the way in which it attacks human beings is known, the best way to attack the disease can be demonstrated, and the disease possibly stamped out. Anyhow, by research work invaluable help can be given to India, and every rupee spent on research work, laboratories, etc., both those at the tropical schools of medicine and other special laboratories, will return a thousandfold in value.

Research workers are specialists, and if it should be necessary, I would advocate getting men from England for this department.

I have had now nineteen years' experience in civil employ, and having met many medical officers holding civil appointments in various parts of India when on tour, I can state, as a very definite fact, that private practice has declined very materially of late years. Appointments are not now worth in private practice one half of what they were ten years ago.

To take my own province—the United Provinces—I doubt if in more than ten of the civil stations there is any practice at all for the civil surgeon, and in all the large stations it has largely decreased. The reason, I think, is due to the better medical education in India of late years. Many doctors of the assistant surgeon class are turned out by the medical colleges every year, and these either enter government service and practice or go into private practice alone. Many more Indians also go home to the English medical schools and come out and practice in the large towns. These practitioners do not encourage consultations. For political reasons too, I think that the private practice of Indian Medical Service officers has decreased. Indians are much more inclined than formerly to employ their own doctors. Still there is consultation work to be had and a good man will get it. It largely depends on his repu-

tation as a surgeon, physician or ophthalmic surgeon. Indians will still go long distances to see a man with a successful reputation.

Questions for Service Officers.

I have been seven and half years in military employ and 19 years in civil employ during my 26½ years' service in the Indian Medical Service.

I personally have no cause for complaint or discontent, because I have been one of the more fortunate members of the Indian Medical Service in being selected to hold some of the more lucrative and better appointments.

The cause of complaint I have is one which is general to all, namely the slow rate of promotion. Officers should get promotion to administrative rank, if they are selected for it, earlier than they do. It is not good for any service, for men serving in an enervating climate like India to get promotion to important administrative posts when they are feeling the strain of long continued service with probably little leave.

I feel strongly on the question of pay for the whole of the Indian Medical Service, and I consider that a substantial increase is absolutely necessary, if the service is to be a contented one. For the general service the chances of private practice are small, and it is necessary for officers therefore to be well and adequately paid.

In the past, I think there was always a certain amount of suppressed jealousy between the officers of the Royal Army Medical Corps and Indian Medical Service. Speaking candidly, the officers of the Royal Army Medical Corps always considered themselves better administrators as regards the medical work of the army, and officers of the Indian Medical Service considered themselves more experienced and better professionally.

During the war the inequality of promotion has been a very real cause of complaint on the part of Indian Medical Service officers, but I do not know of any cases where it has led to friction between the two services.

The obvious suggestion to remove grievances or friction between the two services is to form out of the two services a unified medical service for India, so combined as to satisfy both services.

As the two services stand at present there is bound, I think, always to be certainly a grievance on the part of the Indian Medical Service owing to the inequality of promotion during the war, and this only to Indian Medical Service officers not being treated fairly in the way of promotion.

I think officers of the unified medical service for India should be eligible for transfer to civil employment after five years' service in military employ. Officers will by that time have gone through all the necessary courses and have had real experience of medical work with the army and in station hospitals.

During the service of an officer in civil employment he should, as I have said above, be reverted to military employment for short periods at regular intervals to keep him in touch with the changes in medical organisation in connection with the army.

At the completion of twenty years' service an officer in civil employ should decide whether he will stay in civil employ or be transferred to military employ as a permanency. After twenty years' service officers should be required to stay in either military or civil employ and look for promotion on whichever side they select.

Special questions.

I think that the demands of European members of the public services for European medical attendance on themselves and their families is based both on racial predilection and on the comparative professional merits of doctors. As regards racial predilection it can be understood that a European would rather have a doctor of his own race to attend his wife and family, although he does not probably care so much about himself; so that the racial preference will always stand high, and in my opinion this fact will influence recruit-

14 February 1919.]

Lieutenant-Colonel H. AUSTEN SMITH.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

ment in the future for the European services in India, as to whether the wives and families of officers will be able to be attended by good European doctors or not.

As matters at present stand in India, and here again I speak confidentially, the professional merits of European doctors stand very much higher than those of Indian; but I think that racial predilection will always be a very prominent factor in influencing favourably or otherwise recruitment for the several European services, whatever the future qualifications of Indian medical men may be.

I do not think that Europeans have been satisfied with the medical treatment they and their families have received from Indian substitutes for European medical officers withdrawn from the charge of troops or civil districts. European officers have met the difficulty either by calling European medical officers from the nearest large civil station, and this often at a good

deal of expense to themselves in the case of civil officers, or they have sent their wives and families to hill stations, where there have been European medical officers; or they have sent them to nursing homes or hospitals in the nearest large stations.

I think that Indian medical officers, and by this I mean natives of India, are efficient to a certain degree, although I have had, as I have said above, a few very good such officers serving under my command.

I think as things are at present that they cannot compare in most cases with the efficiency of European medical officers. I think that Indian medical officers are improving in efficiency, and many of them have done well in this war. I can only speak on this question with a limited knowledge, but inspectors general of civil hospitals and assistant directors of medical services will be able to speak with much more authority and experience.

LIEUTENANT-COLONEL H. AUSTEN SMITH, called and examined.

(President.) He had a total of 26½ years' service, of which 7½ were spent in military employ and 19 in civil. He had spent nearly two years on military duty during the recent war, one year at Brighton, two months in Egypt, and eight months in Karachi.

There should be no Royal Army Medical Corps officers serving in India, except those who were either seconded for service with, or transferred to, the Indian Medical Service. The civil medical service should not be separate from the military. The civil medical service would constitute a war reserve, except for officers holding indispensable civil appointments, who would not be recallable to military duty. The number of these "indispensable" appointments should be large. He would include in the scheme for the war reserve all independent medical practitioners, including the assistant surgeon class.

He would send military officers to civil employ, but would return all such officers, except those holding "indispensable" appointments, to military duty every five or seven years.

Officers should, after receiving their commissions, come out to India, and undergo a course at the new military medical staff college to be established. They should then be attached to one of the schools of tropical medicine to gain experience in tropical diseases. After a period of five years in military employ, they would be eligible for civil employ if they desired it, but owing to the fact that there were not enough civil appointments for all the applicants, not all who desired to go to civil would be able to do so. Indians should be treated in exactly the same way as Europeans.

As he had said in his written statement, a few of the Indian temporary Indian Medical Service officers he had met in the war were satisfactory. One was very good and had since got a permanent commission. These officers suffered from being suddenly put down in a strange environment, for which they were the less suited, owing to having been educated entirely in India. Few of them were of the stamp required to make good officers, nor could they be trusted to carry on an independent charge.

If in the future there should not be a sufficiency of European doctors to look after the families of government officials, difficulties would arise. It might be necessary to provide nursing homes, or to arrange for the admission of European ladies and children to British military family hospitals.

(General Cree.) The auxiliary corps referred to in scheme 'A' must necessarily become subordinate, even if its members are under the same rules for pay, promotion and appointment to administrative posts as the regular Royal Army Medical Corps. He did not see much advantage in these proposals over the present arrangement, under which the Royal Army Medical Corps and Indian Medical Service worked side by side. He thought that a unified military service was essential, but the service he proposed would necessarily, for some time, be dependent for officers on the Royal Army Medical Corps.

The prospects of civil employment had in the past undoubtedly been one of the great attractions of the Indian Medical Service and should be retained in the new service. He might, however, agree to a separate civil medical service, provided that close contact was maintained between it and the military service.

The civil medical needs of India were increasing enormously, and there was a great future before the civil medical service.

The civil needs should be largely supplied from the military service, but for a certain number of special appointments doctors should be brought out specially from Europe, where suitable officers for the post were not available in the service; the desire being to get the best possible candidate for the special post.

(General Hehir.) The publication of a statement to the effect that the question of the improvement of the Indian Medical Service was under consideration would help to restore the confidence of the medical schools at home. If there was an Indian Medical Service officer suitable for the post of Director, Medical Services in India, he should be appointed. He favoured the idea of compulsory examinations before promotion to the rank of major and lieutenant-colonel. He also favoured the system of promotion by selection to the rank of lieutenant-colonel, and would abolish the "selected list" of lieutenant-colonels in the Indian Medical Service.

The practice of sending military officers to civil employ raised the professional standard in the military service.

Training in tropical medicine should be carried out at one of the special schools recently established, and not at the proposed military medical staff college.

(General Hendley.) Indian officers trained even partly in Europe were more efficient than those trained wholly in India. All officers admitted to the service should have qualified in Europe.

He approved of the grant of scholarships to Indian medical students, but an undertaking to enter the military medical service should be one of the conditions essential to their being granted, provided that the candidate was successful at the entrance examination.

The Women's Medical Service would probably assist to some extent to overcome the difficulty arising from a want of European government doctors to treat the families of officials.

(Mr. Hignell.) The present discontent in the Indian Medical Service, dated from 15 or 20 years back. The chief causes of it were inadequacy of pay, and disappointment at being unable to get into civil employ as quickly as had been anticipated. The prospect of civil employment had been and was now one of the chief attractions of the Indian Medical Service.

He favoured the maintenance of a large war reserve for the military service, and of adequate facilities for study leave.

He considered that the civil medical needs of India had been subordinated to the military requirements, to the detriment of the former.

14 February 1919.]

Lieutenant-Colonel H. AUSTEN SMITH.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

The lack of European doctors was only felt in the districts, not in large cities. The maintenance of one European and one Indian civil surgeon in each district would be of great value, but would entail great additional expenditure.

(General Giffard.) If a separate civil medical service were established, in addition to the employment of military officers on civil duties, the prospects of a civil career would not prove a great attraction for the military service, unless all the higher civil appointments were reserved for officers of the military service.

In spite of the Adjutant-General's opinion to the contrary, he did not hold that *continuous* military service

was essential, in order that an officer should be a successful military medical administrator. If proper arrangements were made for periodical military training there was no reason why an officer reverting from civil to military employment after 20 years' total service should not fill a military administrative appointment successfully.

(President.) A civil medical service apart from the military reserve to be maintained in civil employ might be necessary, because the civil needs would be greater than the numbers required for the military reserve. But it was essential to reserve a certain definite proportion of the higher civil medical appointments to be filled by officers belonging to the military service.

LIEUTENANT-GENERAL SIR T. J. O'DONNELL, K.C.I.E., C.B., D.S.O., Director, Medical Services in India, called and examined.

(President.) He had come out to India first about 1892, for about five years. Again in 1905, for a similar period. He came out once more about three years ago to his present appointment. Altogether, he had seen a great deal of service in India. He had been in France for about 1½ years.

He was not in favour of any of the schemes 'A,' 'B,' 'C' or 'D.' The nearest approach to his ideas was scheme 'A,' but he did not know whether the proposals regarding the auxiliary corps would satisfy the political aspirations of Indians, or meet with the approval of the Government of India. Subject to this proviso, he considered that this scheme provided a fairly satisfactory solution of the problem.

He considered that, if there was to be one unified military service for India, it ought to be either the Royal Army Medical Corps or the Indian Medical Service. He did not see how the two were to be combined, as was suggested in the various schemes.

He was opposed to a combined civil and military service, as he did not think that an efficient military service would ever be obtained if it were only a stepping stone to the civil.

He fully endorsed the view put forward by the Adjutant-General that no medical officer should be allowed to hold a high administrative office in the field, unless he had served continuously in military employ. This opinion was supported by his experience in France. There had been many eminent civil doctors employed in France in the collecting and distributing areas, but for purposes of administration it had been found that officers of the regular service with two or three years' experience were much more suitable than any of these civilians. This argument applied to Indian Medical Service officers who had spent much time in civil employment. They were not up to the standard required for high administrative posts in the field. An officer's military education must go on all the time, as ideas were constantly changing, and unless an officer was always in touch with military developments, he was not fit to command a large military medical unit.

He would put forward a rather different proposal himself. The Indian station hospital system had been recently inaugurated, and it ought to be given a chance. At the present moment the Indian Medical Service was not a corps; it was a collection of individuals. Although the regimental medical officer in the British Army had been done away with in the early seventies, it was not until comparatively recent years that the Royal Army Medical Corps had attained its present standard of efficiency. The system of regimental medical officers in the Indian Medical Service had been only recently abolished, and this service should now be given a chance of developing into a corps, as the Royal Army Medical Corps had done. This new corps, which the Indian Medical Service would form, should be for purely military duties only. For civil duties there should be a totally distinct civil medical service.

If the civil authorities desired to obtain the services of a particular officer belonging to the military medical corps, this could be permitted. Similarly, if the Commander-in-Chief required a consultant physi-

cian or surgeon for the army, a suitable officer should be obtained from the civil medical service. There would thus be an interchange; but otherwise the military service should be kept separate from the civil.

All members of the civil medical service should go through some period of military training, this being one of their conditions of service, so that they would act as a reserve and have sufficient training for employment at the base and on lines of communication, etc.

(General Hehir.) With regard to the suggestion that the system of lending military medical officers to the civil medical service, if they could be brought back when required, might prove a useful asset in regard to the treatment of soldiers in India, as such officers would come back with valuable professional experience, he considered that the sort of patients that the civil medical service treated were, as a rule, quite a different class altogether from soldiers. In big civil hospitals the medical officer saw a very varied collection of cases; whereas the ordinary civil medical practitioner did not.

Regular officers of the Indian Medical Service, who had been in military employ all their service had, on the whole, made successful military medical administrators. But of those who had spent a long time in civil work, although there were some brilliant exceptions who had taught themselves in a very short time, he did not think that they had been successful in military administrative appointments.

With regard to the suggestion that present Indian Medical Service officers did not attach sufficient importance to their military duties, he had spoken to many Indian Medical Service officers, and all had given him to understand that they looked upon the military as a stepping stone. There were exceptions to the rule, no doubt.

He agreed that there should be examinations for promotion from captain to major and major to lieutenant-colonel as that was the only way to maintain the standard of efficiency. Regimental medical officers in the Indian Medical Service had not many opportunities of keeping up their professional knowledge and unless there were examinations of some sort they were liable to fall behind. Royal Army Medical Corps officers, on the other hand, have to go through a course at Millbank, after they had been in the service for seven or eight years, and had to pass examinations for promotion. This ensured that, no matter in what part of the world an officer had been serving, his efficiency was kept up to a definite standard.

With regard to the efficiency of the Indian officers of the Indian Medical Service, the quality of their work was very variable. He had had some good men and some who were the reverse. He thought, however, that the training which these officers had received in the small colleges at Rawalpindi and Poona had made a great difference in the quality of their work. They were on the whole very amenable, although there were some who could not be improved by training. The majority, however, shaped well.

There should be some machinery to limit the number of Indians to be admitted into the military service. The proportion should not in any case exceed

14 February 1919.]

Lieutenant-Colonel Sir T. J. O'DONNELL.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

10 per cent. Indians should also be very carefully chosen, with regard to their caste, character, and social qualifications, before being allowed to compete in the entrance examination.

He approved of the proposal to establish a board to select officers for promotion.

With regard to the suggestion that the present conditions in the Indian Medical Service are not sufficiently attractive for recruitment of the kind wanted, he thought there was not very much difference between the pay of the Royal Army Medical Corps officers and that of the Indian Medical Service. They had no difficulty in getting recruits for the Royal Army Medical Corps. There was one point, in connection with the Indian Medical Service, which he thought ought to be considered, and that was the question of passages home for the officers and their families. He thought that an important matter, since Indian Medical Service officers, for the most part, did not belong to India. The length of the intervals after which free passages should be granted was a matter for decision.

He agreed with the suggestion that a military medical staff college for Indian Medical Service officers should be started in India. At the same time he thought that Indian Medical Service officers ought to be allowed to go home and go through a course of study at the Royal Army Medical College. There should be the same interchange between India and England in this respect, as now takes place in the case of the Staff Colleges at Camberley and Quetta.

He did not agree with the suggestion that the assistant surgeon should be removed from British station hospitals. He thought that such a course would do away with the help of a very valuable class of men, and he did not know where they were going to find an outlet for them.

With regard to the employment of Royal Army Medical Corps rank and file in British station hospitals in India, it would certainly be necessary to devise some means of abolishing the present system under which regimental soldiers are withdrawn from their units and trained as nursing orderlies. This system results in a waste of fighting men and does not produce the most highly trained nurses. He suggested that a certain proportion of the trained nursing section of the Royal Army Medical Corps should be employed in India. The nursing in Indian hospitals was also unsatisfactory, and should be improved.

It would be open to the Government of India to bring men out from England as consulting surgeons to the army; it would also be open to them to bring out for the civil medical service well known men from home for a certain number of years.

He was in favour of a proposal to attach one or two lady nurses of the Queen Alexandra's Military Nursing Service to each large Indian station hospital for purposes of supervision and training, but he would not employ them actually in nursing duties.

With regard to the proposal for a war reserve contained in scheme 'C,' he would make everybody in the civil medical service a potential member of the war reserve. He would not employ any one in this service unless he undertook to come out in case of war. We would have to depend on this condition of employment for our reserve. There had been great difficulty in getting sub-assistant surgeons to undertake military service, and he thought that liability for such service should be one of the conditions of their bond. He would press that point very strongly.

(General Hendley.) He thought that a purely military medical service would attract officers from England. The Royal Army Medical Corps come out to India on practically the same conditions. He did not think that there would be any difficulty in obtaining recruits, provided that the conditions of service were made sufficiently attractive.

He favoured the grant of higher rates of pay to European officers than to Indians, as the latter were living in their own country. This difficulty might be

overcome by the grant to Europeans of free passages to England and back.

With regard to getting a good type of European for the civil service, he had been recently talking to an Indian Medical Service officer, who said that a purely civil service without military rank would be less attractive than the present Indian Medical Service. Pay would not necessarily have to be greater in the civil than in the military service. Private practice would doubtless be sufficient to attract men.

He favoured the suggestion to grant scholarships to specially selected Indian medical students who had completed three years' study and send them to England to finish their education, preparatory to entering for the competitive examination. The selection should be very strict to guarantee the proper class of officer.

He had been embarrassed on account of demands for European doctors in place of Indians, but he attributed this to racial prejudice rather than to lack of efficiency in the Indian.

(Mr. Hignell.) It was imperative that liberal concessions in the matter of study leave should be granted, whatever scheme was adopted.

The Royal Army Medical Corps had no prospects of civil employ and private practice was not encouraged. This had certainly not affected the popularity of the Corps. The authorities set their face against private practice, on the principle that an officer should devote his whole time to his military duties. The Royal Army Medical Corps had recently obtained recruits of the proper stamp, and he anticipated no difficulty in this respect except such as would arise from the general post-war shortage of doctors.

(General Giffard.) The reason why civil employment renders a military medical officer unfit to hold an administrative post was that he had no opportunities of studying military medical administration. He maintained that continuous service in the army was absolutely essential.

He did not favour the idea of allowing officers of the military service to go to civil after, say, seven years' military duty, and then return to military later on. They should only return back to military in case of emergency. They should not be eligible for further promotion after they had passed into civil. The object of this was to ensure that no one, who had not been continuously in military service could hold high administrative military posts. Subject to this he was in favour of giving the reserve as much military training as possible; but rather than have a reserve of officers holding comparatively high military rank, to whom appointments suitable to such rank would have to be given, he would prefer to have a reserve of doctors with but little military training, who could, on mobilisation, be employed on professional duties.

He had seen the work of Indian medical officers in France. Among the regular officers there had been several good men, and others that were not so good. They got on well with the British officers and British troops.

(Mr. Hignell.) He would keep in military employ a sufficient reserve to meet the requirements of a small frontier war. This reserve would constitute the leave and study reserve of peace time. Liberal concessions should be given for study leave.

(General Cree.) The idea would be to have a regular medical service of such cadre that it would provide for all administrative purposes in war time; and that this cadre could be filled up with private practitioners.

(President.) He thought that no radical change in the present dual military service was required at present. The question was wrapped up in matters of future policy and its decision would largely depend on whether the War Office or the Government of India were going to be responsible for the army in India. If there was to be any change, either the Royal Army Medical Corps or the Indian Medical Service should undertake all medical duties in connection with the army in India.

15 February 1919.]

Major E. H. V. HODGE.

*(The schemes and questions referred to by witnesses are contained in Volume III.)***At Delhi, Saturday, 15th February 1919.****PRESENT:**THE HON'BLE SIR VERNEY LOVETT, K.C.S.I., I.C.S. (*President*).

MAJOR-GENERAL G. CREE, C.B., C.M.G., A.M.S.

MAJOR-GENERAL P. HEHIR, C.B., C.M.G., C.I.E., I.M.S.

MAJOR-GENERAL H. HENDLEY, K.H.S., I.M.S.

THE HON'BLE MAJOR-GENERAL G. G. GIFFARD, C.S.I., I.M.S.

S. R. HIGNELL, Esq., C.I.E., I.C.S.

LIEUTENANT-COLONEL A. SHAIRP, C.M.G., Indian Army.

LIEUTENANT-COLONEL G. B. A. RIND, Indian Army.

MAJOR A. A. McNEIGHT, I.M.S. (*Secretary*).

MAJOR E. H. V. HODGE, I.M.S., Deputy Assistant Director, Medical Services, Army Headquarters, India.

Written statement.

With regard to how far the civil side reserve has proved of value in the war, it may safely be said that if we had not had this reserve it would have been quite impossible to have met our necessities. During 1914, 301 medical officers proceeded on service, of these 111 were in military employ, 163 in civil and 27 were private practitioners. Without this reserve we should have had to draw on private practitioners and such men as could be spared from home without any previous experience in tropical medicine and, from our point of view, inefficient. As it was, by the 14th of October, the civil side had lent 172 officers professionally skilled, with knowledge of tropical conditions and Indian people and all of whom had had some previous military training.

This number with the original military officers of the Indian Medical Service formed a nucleus round which the present military service of over 1,400 was built. By this time the military side has been increased by 323

permanent officers from civil, 155 civil assistant surgeons holding temporary commissions and 159 temporary assistant surgeons granted commissions. This in officers only.

The presence of these experienced regulars made it feasible to recruit and use 510 private practitioners who, without this leavening, would have been a large and unwieldy body incapable of carrying on.

The result has been that for our base hospitals we have been able to find our own specialists, and further, have been for all fronts, what is practically the only source of tropical experts.

Much more could be said about the assistance of the civil side in regard to the supply of subordinate personnel. Apart from those handed over they trained large numbers. Not the least important has been the supply of over a thousand dressers, recruited and trained largely by the civil department.

MAJOR E. H. V. HODGE, called and examined.

He had 9½ years of service all of which had been spent in military employ. During the recent war he had first been employed in China with Indian troops. Then he had served 10 months in France and also for some time in East Africa. He joined the office of the Director, Medical Services in India in April, 1918.

When he entered the Indian Medical Service the competition was very keen and all the candidates who passed had taken honours degrees. The standard therefore was high. At that time the chief inducement to young medical men to enter the Indian Medical Service was the prospect of varied civil employment. This weighed very much more with them than the attractions of a military career.

Of the Indian regular officers of the Indian Medical Service whom he had met in East Africa, some had done very well especially when employed with regiments. These were men of high caste.

(*General Cree.*) He was averse to the continuation of the present system under which the medical care of the army in India was shared by officers of the Royal Army Medical Corps and Indian Medical Service. He favoured the formation of a unified medical service to perform both military and civil duties. The Indian Medical Service could not with their present cadre take over all the duties of the Royal Army Medical Corps, but this difficulty could be met by seconding Royal Army Medical Corps officers of all ranks until the Indian Medical Service had sufficiently expanded.

It was necessary that the civil and military services should be united, both in order to obtain the best class of recruits and also to provide a sufficient war reserve. Although the expansion of the military cadre of the

Indian Medical Service up to 3 per mille of troops and followers would reduce the reserve, which it was necessary to maintain in civil, it would not abolish the need for such reserve. He considered that officers of the military service profited greatly by the professional experience which they obtained when they transferred to civil employ. Professional experience in military hospitals, even under the station hospital system is small.

In order to maintain military efficiency, it was very desirable that officers of the Indian military medical service should attend courses at a medical staff college in England and officers of the Royal Army Medical Corps courses at a similar college to be established in India. If the Royal Army Medical Corps ceased to serve in India it would be impossible to obtain nursing orderlies of that corps for duty in British hospitals in this country. It would therefore be necessary to recruit for a special nursing service.

(*General Hehir.*) He favoured the amalgamation of the Indian Medical Department and the proposed Indian Hospital Corps into one corps and, though it might be desirable, it was not necessary that the officers of the Indian Medical Service should form part of the same corps.

He would approve of the introduction of examinations before promotion to the ranks of major and lieutenant-colonel, and would approve of promotion to lieutenant-colonel being made by selection, but only after the relation between the military and civil services had been definitely defined.

The best administrative officer available in India for the post should be appointed Director, Medical Services.

15 February 1919.]

Major E. H. V. HODGE.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

This appointment should at least be equally open to the Indian Medical Service as to the Royal Army Medical Corps.

If the number of Indians in the military service were increased there would be difficulty in obtaining European recruits.

(Colonel Shairp.) He considered that the Royal Army Medical Corps officer was professionally inferior to the Indian Medical Service officer.

(General Hendley.) If the Indian military medical service were entirely separated from the civil medical service the best class of European recruits would not enter the military service.

(General Giffard.) Although a certain number of officers in military employment maintain their professional efficiency, it was on the whole advisable for officers to spend a certain time in civil.

Specialists in the military medical services did not, as a rule, possess very high qualifications in their special subjects. Officers with really high qualifications and experience could be obtained from civil when required for employment as specialists with the army.

(Mr. Hignell.) His dissatisfaction with the conditions of service in the Indian Medical Service, dated from the time when he was in France where he associated with more officers of the service and discussed matters with them. The chief causes of discontent were the uncertainty of the future of the Indian Medical Service and the inadequacy of the pay of officers below the rank of lieutenant-colonel. He was anxious for civil employment. He did not consider that professional efficiency could be wholly achieved even under the station hospital system and by introducing compulsory periods of study.

LIEUTENANT-COLONEL CORRIE HUDSON, D.S.O., I.M.S., Officer Commanding, Indian Station Hospital, Ambala.

Written statement.

I consider that two military services such as the Royal Army Medical Corps and Indian Medical Service in one country are unworkable and that they have proved themselves inefficient.

At present the head of the two military services is always appointed from the Army Medical Service and never from the Indian Medical Service. The Indian Medical Service consequently loses prestige and efficiency. Practically all the defects in the Royal Army Medical Corps and Indian Medical Service arise from the above anomalies.

Schemes 'B' and 'C' are very satisfactory solutions of the present difficulties, although in both there are one or two points that would be better altered. These schemes face the situation. The schemes 'A' and 'D' evade the issue and are for all practical purposes just the same thing as the present Royal Army Medical Corps and Indian Medical Service all over again, substituting auxiliary corps or Indian Army Medical Corps for Indian Medical Service.

Scheme 'C.'

As regards scheme 'C,' I would suggest the following alterations:—

(i) Call the unified medical service the Royal Army Medical Corps or Royal Indian Medical Corps instead of Indian Medical Corps.

(ii) Recruit it from five sources (scheme 'C,' para. I (e)):—(1) Present Indian Medical Service officers in military employ. (2) Royal Army Medical Corps officers volunteering for permanent service in India (as Royal Engineer and Royal Artillery). (3) Duly qualified medical men from England, Scotland, Ireland, Canada, South Africa or Australia, etc., of European birth, after a competitive examination for the Indian Medical Service. (4) Duly qualified Indian gentlemen, after a similar examination, who by birth and education would be acceptable to Indian officers and sepoys and agreeable companions to their European colleagues. (5) If necessary Royal Army Medical Corps officers (not above the rank of major, volunteering or ordered to do a 5 years' tour in India. (Pay, etc., as under.) All the above to be called the Royal Army Medical Corps or Royal Indian Medical Corps as decided upon.

(iii) Para. 1 (d).—No civil Royal Indian Medical Corps officer to come back after 15 years. Never to be made Assistant Director, Medical Services, as at present.

(iv) Para. 1 (g).—All appointed from the Royal Indian Medical Corps.

(v) Para. 1 (h).—No. Not unless civil come back to military, in which case yes.

(vi) A.—*The Indian Military Medical Service.* Para. 4.—Organisation—call Royal Army Medical Corps instead of Indian Medical Corps.

(vii) Para. 5 (a), (b), (c), (d).—All appointed from the Royal Indian Medical Corps. (e) (1) Includes present Indian Medical Service, permanently transferred Royal

Army Medical Corps officers, future Royal Indian Medical Corps officers, and promoted assistant surgeons. (2) Seconded officers of the Royal Army Medical Corps (for a period of 5 years). All to be called Royal Indian Medical Corps including the seconded Royal Army Medical Corps officers.

(viii) Para. 10.—Director, Medical Services, only to be appointed from the Royal Indian Medical Corps never from Home—an essential point.

(ix) Para. 16.—The terms of service of both should be identical (once the Royal Army Medical Corps officer has permanently joined the Royal Indian Medical Corps).

(x) Para. 17.—No Army Medical Service officers from Home.

(xi) Para. 19.—This paragraph introduces the old element of a dual service. It is necessary that the service should be a medical service for India, and not a service such as this paragraph suggests. The Royal Army Medical Corps should be permanent, or on tour for a period of five years only, and in the latter case they should only be junior officers and never hold any administrative appointments. This is only fair, as the men who spend their life out in India should not be supplanted by men temporarily sent out from England.

(xii) Para. 20.—All administrative posts to be filled from the Royal Indian Medical Corps.

(xiii) Paras. 23 and 24.—Civil lieutenant-colonels should never come back.

(xiv) Para. 28.—Military assistant surgeons eligible (if fit) for commissions. Military sub-assistant surgeons eligible to become assistant surgeons and so to commissions (if fit).

(xv) Para. 31.—Civil Royal Indian Medical Corps up to 15 years. Increased cadre of Royal Indian Medical Corps (this would allow a just proportion of furlough). Home reserve does not seem advisable and the distance to come for training is too great.

(xvi) Para. 32.—Home reserve not advisable. Present private nurses could be developed as a war reserve.

(xvii) Para. 38.—Yes, but all from the Royal Indian Medical Corps.

(xviii) Para. 39.—From the Royal Indian Medical Corps.

(xix) Paras. 38 and 39.—It is only by having such appointments open to a service that the service becomes a good one. If all the specialist appointments are given to men from Home the service would suffer.

(xx) Para. 44. (1) From civil only, unless civil are allowed to send back Assistant Directors, Medical Services, from civil. The idea is, however, I think, wrong; juniors might exchange but not seniors.

Officers to have furlough of 1 year after every 4 years, and their passages paid Home and back; and I should advise that their families receive free passages too. Officers would readily keep up their professional knowledge to the Home standard if they

15 February 1919.]

Lieutenant-Colonel CORRIE HUDSON.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

were given the chance, but lack of leave and poverty prevents them.

Questions for Witnesses.—(Q. 2.) Such a scheme should be acceptable to the War Office. The War Office could not object to India having a medical service of its own.

The initial transfer of a number of Royal Army Medical Corps officers to the Royal Indian Medical Corps cannot be worse for the War Office than supplying a continual flow of Royal Army Medical Corps officers to India.

The scheme would meet the needs of the army in India, both as regards European and Indian members of it, and would meet the aspirations of the Indians. It would be efficient which no one can say of the mongrel dual service we have suffered from.

Criticisms:—

- (a) Duality of control would go.
- (b) It would permit medical men to have ambitions to work. The present system kills ambition and fosters mediocrity.
- (c) The present system produces inefficiency (note the first class bacteriologist refused post of bacteriologist in France (expeditionary force) because he was Indian Medical Service and endless other examples).
- (d) Friction between the two services would cease as their interests would not clash.
- (e) It would give European doctors to those Europeans who desire European doctors. The present hard and fast division of Royal Army Medical Corps and Indian Medical Service is childish. One hears of cases of the one or the other being quite shocked if they have to attend to some person "not laid down in regulations as a person under their charge."
- (f) Indians would appreciate the change (I know this from actual knowledge).
- (g) It would give India medical men throughout who understand and like India, and not men who come here for a short period only, and who often dislike India and the Indians.

(Q. 3.) Yes. Yes. Merely a matter of sufficient pay and leave.

(Q. 10.) Yes. One year after every four years and a free passage for the officer and his family. If this were given the officer would do the rest.

Special Questions.—(Q. 1.) Even if the standard of the European and Indian members of the service was brought up to the same level I should say that 50 per cent. of European officers and 99 per cent. of European women would prefer their own countrymen as doctors.

(Q. 2.) No. Called in European doctors and either taken their services for nothing, or else rather grudgingly paid for such services.

(Q. 3.) The Indian officers of the service and the recently joined European officers of the service are not up to the standard that was prevalent some years back. (Instances of marked inefficiency quoted if necessary—eye case, abdominal tumour case, musculo-spiral nerve case.)

Questions to be asked of Service Officers.—(Q. 1.) 20 years of which four years was as staff surgeon, Bangalore, which comprised civil surgeon in addition to staff surgeon.

(Q. 2.) Yes; under the following heads:—

1. A dual head D. M. S. and D. G., I. M. S.
2. Pay.
3. Promotion.
4. Work.
5. Rewards.

(Q. 3.) Individually No; collectively as a service, Yes.

(Q. 4.) Yes. One military service: one head; and fair dealing. This one service to be called Royal Army Medical Corps or Royal Indian Medical Corps. On the whole I should say call it Royal Army Medical Corps.

(Q. 5.) (a) 5 years. (b) 15 years.

Scheme embodying the alterations suggested for schemes 'B' and 'C.'

1. There should be a civil and military service. They should be administered separately. Military medical officers to be seconded to the civil after 5 years; returnable at option up to 10 years; then to remain in civil and not to return.

2. The military service (the seconded civil) to be called the Royal Army Medical Corps or Royal Indian Medical Corps.

3. Recruited from (1) Present Indian Medical Service in military employ. (2) Royal Army Medical Corps officers volunteering for permanent service abroad. (3) The future medical officers (1) obtained from European medical men after competitive examination at Home. (4) Indians of good birth, after an examination the same as above; Indians who should be acceptable to Indian officers and sepoys and agreeable companions to those they meet professionally. (5) Royal Army Medical Corps officers (not above major) seconded from Home for a period of 5 years (pay, etc., as under). If possible volunteers.

4. The head of the service should be an officer selected from (1), (2), (3) or (4). There should be only one head.

5. All administrative posts to be given to (1), (2), (3), (4). Class (5) could be Deputy Assistant Director, Medical Service, if suitable.

6. (1), (2), (3), (5) to look after Europeans. (4) to look after Indians with the help of the Europeans (1), (2), (3), (5), as long as needed.

7. (1), (2), (3), (4), (5) can hold specialist appointments.

8. (1), (2), (3), and (5) can hold command of a British station hospital or an Indian one. (4) Can hold command of an Indian station hospital.

9. Pay and Pensions.—A definite similar rate for all, but (1), (2), (3) to have a foreign allowance, a foreign pension and (5) have a 5-years-portion of the same.

10. Furlough one year after four and at similar intervals afterwards. Passages for families.

11. Assistant Surgeons.	} All to be Royal Army Medical Corps or Royal Indian Medical Corps as decided.
Sub-assistant surgeons.	
Nursing orderlies.	
Army Bearer Corps.	

12. Bhisties.	} All to be Indian Hospital Corps or Army Hospital Corps.
Dhobies.	
Ward servants, etc.	

13. To have a sufficiency of all the above (11 and 12) to give all furlough and so create a reserve.

14. All (i), (ii), (iii), (iv) and (v) who have not already been through Millbank or Netley and all assistant surgeons, sub-assistant surgeons, nursing orderlies and Army Bearer Corps to go through the proposed college (like Millbank), (iii) and (iv) classes in future to go through the college out here and not Millbank.

15. Promotions.—Officers as for the Royal Army Medical Corps (Examinations, etc.).

Assistant surgeons, if fit, can become lieutenants and sub-assistant surgeons, if fit, can become assistant surgeons and later, if fit, lieutenants.

Nursing orderlies as at present Army Bearer Corps up to subadar-major.

This scheme embodies the few alterations that I think schemes 'B' and 'C' need.

The name Indian Medical Service or Indian Medical Corps, Royal Indian Medical Corps, or Royal Army Medical Corps seems immaterial if the service is unified

* *Viz.*, duly qualified men of European birth as before obtained for Indian Medical Service.

15 February 1919.]

Lieutenant-Colonel CORRIE HUDSON.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

and the five methods of recruitment laid down above are adopted. It is essential, however, that all appointments are given from these five sources and

that no other Royal Army Medical Corps officer⁽¹⁾ or Harley Street specialists should be appointed from England.

LIEUTENANT-COLONEL CORRIE HUDSON, I.M.S., called and examined.

(Mr. Hignell.) Witness joined the service in 1899 and had spent all of his time in military employ except for four years when he was staff surgeon at Bangalore. His appointment there included both civil and military duties. He served in the recent war in France for nearly two years, from 1914 to July, 1916. Since his return he had served on the North-West Frontier, at the Staff School at Saugor, and then as Commandant of the temporary Indian Medical Service officers' school at Rawalpindi. At present he was Commandant of the Indian station hospital at Ambala. He had no desire to obtain civil employment.

(General Giffard.) He saw no objection to there being one united medical service for India, comprising all the various departments. There might be some difficulty in combining the civil and military services but he saw no reason why this should not ultimately be carried out.

He thought it important that officers of the Indian Service should pass their whole careers in India. If it were necessary to employ Royal Army Medical Corps officers at all, it should only be junior officers. The Director, Medical Services, should be an officer of the Indian service.

He thought that there was no reason why a military medical officer should not maintain his professional efficiency even if he spent his time in military employ.

He would have no objection to the establishment of combined hospitals in which British and Indian soldiers and civil patients would be treated.

If a separate civil medical service was established, recruitment for the military service would suffer.

He said that he would certainly find a place for the assistant surgeon class (Anglo-Indian) in the proposed large service, even if they were ousted from British hospitals, but he would insist upon their having European qualifications.

He thought that much depended on the training that a student received in his college in India as to the necessity for sending him for a further course of training in England. The training at Home would be suitable for imparting a knowledge of service conditions, as his experience had been that the Indian student had a very fair knowledge of medical and surgical work. He thought that an Indian who had had a Home training was certainly better than one who had not. The best Indian officers would be those who had finished their professional studies and qualified in England and had then undergone a course at a military medical staff college in India.

(General Hendley.) The chief cause for discontent among Indian Medical Service officers was that they were serving under two, if not three, masters. He would remedy this by having only one service and one head. Personally, even though his pay were doubled he would not care to continue serving in India unless these conditions were changed.

He knew of no causes for individual friction. Speaking collectively, however, one cause of friction lay in the fact that the head of a service naturally took more interest in members of his own service than in those of another.

He thought that a limit should be placed on the number of Indians entering the service. He presumed that the unified service would have a proportion of Indians to look after the Indian troops and a proportion of Europeans to look after the Europeans. The proportion should correspond to the numbers of the troops of the two races. British troops should be under the charge of European medical officers. Indian officers could also treat them, but his experience had been that Europeans prefer to be treated by men of their own race.

Speaking logically Indians could be placed in charge of combined British and Indian station hospitals, but personally he considered that they were not fit to hold such posts. In his service he had come across very few Indian officers who were fit for administrative posts, in spite of the fact that some of them were highly qualified.

(Colonel Shairp.) He had mixed with a number of Indians while he was in command of the Indian Medical Service School at Rawalpindi and had discussed matters with them freely, and they had said that they would never come into a service like the present Indian Medical Service.

(General Hehir.) He was in favour of examinations being instituted for promotion from captain to major and from major to lieutenant-colonel. He was not disposed to do away with the selected list of lieutenant-colonels.

He was inclined to favour the proposal that officers should go periodically to civil employ and then return to military. He thought this would benefit the army, but there ought to be a time limit after which officers could not return to military.

It was very essential that free passages Home should be given to officers and their families. If this concession were given they would have an opportunity of keeping their professional knowledge up to the Home standard. At present the difficulty in paying for passages often prevented officers from taking study leave.

(General Cree.) If the Royal Army Medical Corps in India were replaced by an Indian Medical Corps, one of the greatest causes of complaint would be removed.

He did not think that at present the Indian Medical Service could take charge of all the military posts in India, without the aid of the Royal Army Medical Corps. This might be done in a few year's time.

He favoured the civil service being a portion of the military. Even if the civil needs of this country increased enormously in the course of the next few years the civil medical service should still be part of the Indian Medical Corps.

The prospects of civil employ were undoubtedly a great attraction in the past but this is not so now. The civil portion of the service should be retained as it offers attractions to recruits and affords military officers excellent opportunities of professional training.

The medical work which an officer gets in military employment is not sufficient. He should occasionally be sent into civil. Military work is, however, essential and should be the first consideration.

The appointment of officers who had spent most of their service in civil employ to administrative military posts was a mistake. For such appointments almost continuous military service was necessary.

There had formerly been two classes of candidates for admission to the Indian Medical Service. One class were attracted by the prospects of a civil, the other by those of a military career. Even if the two services were separated the two classes of recruits would still be forthcoming.

If there is an Indian Medical Corps for the whole of the military medical work in this country there should be a definite social standard for the Indian officer. Only candidates of good caste should be admitted.

(Mr. Hignell.) The development of the station hospital system for Indian troops combined with the grant of adequate study leave and free passage home would obviate the need for making military officers take up civil employment in order to maintain their professional efficiency.

¹ Other than the Royal Army Medical Corps noted in ii and iii.

15 February 1919.]

Major H. W. PIERPOINT.

(The schemes and questions referred to by witnesses are contained in Volume III.)

MAJOR H. W. PIERPOINT, I.M.S., O.C., Indian Troops, War Hospital, Ambala.

*Written statement.**Questions for witnesses.*

(Q. 1.) (a) Royal Army Medical Corps none, other than in the matter of pay. The Royal Army Medical Corps, while seconded for service in India, should receive exactly the same pay as the European members of the Military Indian Medical Service.

The Royal Army Medical Corps had, before the war, attained a high degree of efficiency: as a result of the war its organisation and administration have reached the highest level of efficiency that a medical service can reach, in my opinion.

(b) Indian Medical Service (1) Military. The military side of this service will, as a result of the adoption of the Royal Army Medical Corps system of organisation, resemble that service; thus organised, it should prove as satisfactory for the Indian Army as the Royal Army Medical Corps does for the British Army. (2) Civil. This is in urgent need of complete reorganisation.

(c) No; A and D are wholly bad; C is the only scheme that commends itself to me in any way, and that only in part.

(Q. 2.) The present organisation of the military side of the Indian Medical Service should meet with the approval of the War Office, since it is now modelled on Royal Army Medical Corps lines; it should also meet the wants of the Indian Army.

(Q. 3.) The attractiveness of the service, and, for the present, the proportion of Europeans, depend on three things:—

- Congeniality of work.
- Pay and pension.
- Conditions of leave.

The Indian Medical Service, military and civil, has been unattractive for some years. The military side of the Indian Medical Service, since the recent introduction of Royal Army Medical Corps methods, is now much improved. In the future civil Indian Medical Service the organisation should provide that, so far as the interests of the service permit, men are posted to congenial appointments. All appointments in the provinces should be made by the provincial head of the medical services, and by him only, with the approval of the Director-General, Indian Medical Service. He only is the best judge of the professional abilities of the officers serving under him, and he only is able to post the right men to the right places.

The pay of the Indian Medical Service is insufficient and should be substantially increased. The European members should receive a slightly higher rate of pay than the Indian members of the service; such increase should be based on an actuarial calculation of the increased morbidity and mortality caused by residence in India.

All the schemes assume that a unified medical organisation is necessary for India. None of them give any reason for that assumption. A unified medical service for India is unnecessary, undesirable and wholly unpracticable. Difficulties in the control and administration of two similar but separate services may occur undoubtedly, but they are few compared with the difficulties that would be met with in attempting to control, under one administration, services with such different functions as have the army medical services on the one hand, and the civil Indian State medical service on the other.

All the schemes appear to be lop-sided and to invert the importance of military and civil medical needs. The medical needs of an army of from one to four hundred thousands can hardly be compared with those of a population exceeding 300,000,000. A medical service for India should be based upon the medical needs of India. The military medical requirements of the army are very small compared with the civil medical needs, and, in India, could be complied with many times over from a properly organised State medical service.

The present Royal Army Medical Corps organisation for the British Army in India is wholly admirable; any tampering with it will impair its efficiency and introduce many undesirable and complicating factors. The members of the Royal Army Medical Corps are, as a whole, very contented with their terms of service and do not desire any change.

It should be borne in mind that the present system of seconding Royal Army Medical Corps officers fresh from Home is the best guarantee for the maintenance of the present standard of efficiency in that corps, and, as a corollary, of that of the military Indian Medical Service. Those members of the Royal Army Medical Corps that are dissatisfied with their service at the present time are not likely to be an asset in the military Indian Medical Service.

(Q. 5.) The Indian Medical Service, is, in skeleton form, a State medical service, probably the only one in existence at the present time in the British Empire.

Any new scheme of organisation of the Indian Medical Service should, in my opinion, contain the following provisions:—

- (a) No change of title. "Indian Medical Service" accurately describes the service, is an old and honoured title, is associated with the names of a number of men whose pioneer work in tropical diseases is world-famous, is not improved by being changed to Royal Indian Medical Corps or similar merely imitative designations, and there exists no more reason to change the title of the Indian Medical Service than there does to change that of the Indian Civil or other Indian services.
- (b) The head of the service should be Minister of Health for India, in addition to his other responsibilities, and should be a member of the Government and the technical adviser of Government in all things medical and sanitary. The civil administrative medical heads of provinces should have the same position in the provincial governments that they belong to.
- (c) All members of the State Indian Medical Service should have a preliminary training, for a stated period, in military medical work. All should be available for military service in a national emergency.
- (d) Cadre. The strength of this can only be arranged when the requirements of the Indian Army, of the civil population, and the numbers of officers that this country can at present afford, are known. Possible post-war reconstruction of the Indian Army may materially affect the military medical needs.
- (e) The creation of provincial subordinate sanitary services composed of men provincially recruited and trained, in provincial sanitary training institutions, in sanitary inspection work. This service to consist of men of the status of the Home sanitary inspectors.
- (f) The State Medical Service should provide for the needs of the Indian female population. A certain number of medical women with Home degrees or diplomas should be enlisted, and provincial cadres of the female sub-assistant surgeon class formed. It is the duty of the state to undertake this branch of medical work. It has been wholly neglected in the past and left to charitable organisations, missionary enterprise, etc.
- (g) The holding of jail and chemical appointments by members of the Indian Medical Service should cease. Chemical work is best done by chemists, jail work by jailors.

15 February 1919.]

Major H. W. PIERPOINT.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

It is national waste to train men in medicine and then use them as jailors and chemists.

- (Q. 7.) (a) Yes.
(b) Yes.

(Q. 9.) The service should be open, by competitive examination, to British and Indian medical men.

It is essential at present that all possess a Home registrable degree or diploma. When a committee or commission of the General Medical Council declare that the standards of the medical education and examinations in India are equal to the average standards at Home, Indians should be permitted to compete in India; until those standards are attained in India, it is essential that all candidates possess a Home registrable degree or diploma. Until Indians are allowed to compete in India it is obvious that Indian medical men are at a great disadvantage in competing with Europeans. All successful Indian candidates should receive the entire expenses caused by their journeys to and from Europe, residence in Europe, and cost of medical training there.

(Q. 10.) Study leave, for European officers of the Indian Medical Service should be abolished. The long leave granted to these officers affords ample opportunity for the study of the special subjects that they desire to pursue. On the other hand, study leave in Europe with generous financial provisions, should be granted to Indian members of the service.

Facilities for post-graduate study in India are very poor at present.

Long ordinary leave for the Indian members of the service should be abolished. The civil services in England do not need and do not receive long leave. No man living in his own country needs long leave, other than on medical grounds.

(Q. 11.) Research work in the diseases peculiar to India and the tropics should be encouraged in every way possible. Research institutes should be organised in close connection with hospitals in large centres and

should not be placed on hill-stations remote from clinical work and from hospitals.

(Q. 12.) To a very great extent apart from large towns there is very little private practice in the Indian Medical Service.

The causes are:—

- (a) diminished leisure to attend to private practice, owing to the constantly increasing amount of Government work,
- (b) the increase in the number of retired assistant surgeons and sub-assistant surgeons in private practice, and
- (c) an increasing tendency, on the part of the lay public, to go for medical assistance to large centres where the facilities for medical work are greater.

Special questions for service officers.

(Q. 1.) Military service ten. Civil (Political Department) three.

(Q. 2.) Yes.

(Q. 3.) No.

(Q. 5.) (a) Five years.

(b) Five years.

Special questions.

(Q. 1.) The wish of Europeans in India to be attended by European medical men rests about equally upon a natural preference for their own people, and a belief in the greater professional competence of the European medical men in India.

(Q. 2.) In my experience, no. They have met the difficulty by calling in the nearest available European medical officer.

(Q. 3.) That of pre-war Home-trained men is high; Indian medical men trained and recruited in India are not as efficient as those, British and Indian, who have had European medical training and possess European medical qualifications.

MAJOR H. W. PIERPOINT, called and examined.

(President.) He joined the Indian Medical Service in February, 1906, and remained in military until 1912, when he entered the political service in which he was employed until the outbreak of the recent war, since when he had been in military employment. He had not seen active service in the front line, but had in ambulance transports and base hospitals. His civil experience was limited to employment under the Foreign and Political Department.

(General Giffard.) He saw no necessity for a unified service. The Royal Army Medical Corps in India was relatively small compared to the Indian Medical Service. He objected to the idea of forming one large medical service to look after the needs of India in all the various departments, such as military, civil, marine, etc. His chief reason was that this would entail the disappearance of India of the Royal Army Medical Corps. It would also give rise to many difficulties which do not exist at present, as for instance in connection with recruitment. There would also be the racial difficulty.

A medical officer, in order to remain efficient as an administrator, must necessarily stay in the army the whole of his service. Civil experience would undoubtedly be of use to military medical officers, but, other things being equal, the man who had served in the military service was the better man for administrative posts.

With regard to the question whether a doctor could remain professionally efficient if his whole life was spent with the army, he said that the functions of the army medical service were the prevention of disease, the transport of the sick and wounded and their treatment, and these were infinitely more important than anything else.

He thought that Indian Medical Service officers lost part of their capacity for military administration by

remaining for long periods in civil employment. He did not think that an officer suffered any harm by going into civil employment for 5 years and it increased his professional knowledge. He would preclude all senior officers from returning from civil employ to assume important administrative appointments.

He had had considerable experience of the work of officers who had been given temporary commissions in the Indian Medical Service during the late war. Speaking generally, they did not attain a high standard of efficiency. This was partly due to the standards of medical education in India being comparatively low. He would certainly be in favour of the proposal to select for admission to the medical services men who had a European training. Until a body, such as the General Medical Council, declared that the standard of education and examinations in India was equal to the average standards at home, it was essential for all candidates for admission to the medical services to possess a European qualification.

(General Hendley.) The reason which had induced him to enter the Indian Medical Service was that he did not care for private practice. The Indian Medical Service at the time of his entering the service, had a very good reputation. A good deal of research work in tropical diseases seemed to be done by its members, and the men were of higher average than the general practitioner at Home. The Indian Medical Service at that time was certainly the leading British medical service.

He thought that the attraction of civil employment brought men into the Indian Medical Service. He did not think that a purely military medical service would attract European recruits; but a purely civil service would, provided the terms were good.

15 February 1919.]

Major H. W. PIERPOINT.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

With regard to the suggestion that the service would tend to become Indianized in course of time, he said that the proportion of Europeans would depend entirely on the attractiveness of the service. The Indian was at a very great disadvantage compared to the European, on account of the poorer standard of education in India, and if the service was made attractive, a larger percentage of Europeans would enter it. He would certainly be willing to help Indians to enter the service; but they should be Indians who had successfully competed in England, and who should receive good pay on account of the fact that the Indian had to go Home for his training and had to incur considerable expenditure on account of fees.

The main cause at present of discontent in the Indian Medical Service was the question of pay. On the civil side it was the lack of organization. There had never been anything in the nature of a survey of the medical needs of India. With reference to the employment of Indian Medical Service officers in jails, from the Government point of view this was no doubt a very economical system, but from the medical point of view it was a sheer waste of medical men. Such medical work as was necessary in jails could as well be done by part-time medical officers.

(General Hehir.) He favoured the suggestion of the Indian Medical Service being converted into a corps with assistant surgeons and sub-assistant surgeons as warrant officers, and the proposed Indian Hospital Corps as its rank and file.

With regard to the suggestion that sending officers from the Indian Medical Service to civil employ and

getting them back would improve the standard of professional treatment in military hospitals, he thought that the lines of surgery and medicine were quite different in the civil and military services, and that therefore such a course would not be of value to the army. No doubt there was a variety of diseases in the army, but they were to be found only in a select portion of the community and, while the advantage of such a procedure would be small, the loss on the military side on account of their lack of military training, would not be compensated for.

He favoured the suggestion that Indian Medical Service officers should get free passages Home for themselves and their families at the end of the period of leave. Officers should be compelled to go on furlough at fixed intervals and should not be allowed to forego their furlough at will if they happened to be holding lucrative appointments at the time.

Nursing in Indian hospitals was one of the main defects in India at present. It required re-organization. He thought it rather a disgrace and a scandal. Lady nurses of the Military Nursing Service would be very valuable as supervisors and in charge of operating theatres and for the training of nursing orderlies. They should not, however, perform nursing duties.

(General Cree.) He was opposed to the idea of a new military medical organization in this country, because it would mean the breaking up of the Royal Army Medical Corps. The recruiting for such a service would be very difficult and it would create racial friction.

CAPTAIN K. S. THAKUR, I.M.S., Indian Station Hospital, Ferozepore.

*Written statement.**Questions for service officers.*

(Q. 1.) Nine years and 6 months in the military, no service in the civil department.

(Q. 4.) Yes.

(a) Candidates after passing into the Indian Medical Service should receive their probationary training in an Indian Medical Service college in India and not at Millbank and Aldershot.

(b) Total amalgamation of the services in India and giving of all administrative appointments to the members of the amalgamated service.

(c) Transfers to be allowed in the present emergency to selected officers of the Royal Army Medical Corps, who have not more than 10 years' service into the amalgamated corps.

(d) No transfers to be allowed later except exchanges between the two services.

(Q. 5.) (a) Any time up to 20 years and later only when an officer though professionally capable is unfit for military duty.

(b) Any time up to 20 years' service.

Questions for witnesses.

(Q. 1.) Royal Army Medical Corps officers usually suffer from lack of practical experience as the officers get very few chances of doing any extensive practical work—medical or surgical; moreover professional ability is not as well recognised as ability for office and administrative work.

The military side of the Indian Medical Service has suffered through neglect. Up to the outbreak of the war there had been no improvement for years in the Indian troops' hospitals. This has largely been due to the Indian Medical Service having no effective voice in the administration of the Indian military medical department.

Scheme "B" with a few alterations, as it affords plenty of opportunities for medical officers to be quite conversant with the medical and surgical work required of them. The details of the scheme have however not been worked out by its author. I would

therefore adopt the details of the first part of scheme C with certain modifications which are given below.

(i) Training of military assistant surgeons and civil and military sub-assistant surgeons and some civil assistant surgeons should be so improved that their qualifying diploma may be recognised by the British Medical Council. The present state of affairs is most anomalous as the Indian Government recognises qualifications which are deemed inadequate by those who are best qualified to lay down the minimum of instruction necessary for medical practitioners to make them safe to look after the health of the public. With the improvement in the educational qualifications, the conditions of service of the subordinate medical department will have to be improved.

(ii) Specialists should be appointed from the cadre of the amalgamated service and also from proficient practitioners in India. It would be impossible to get first rate specialists on pay usually given by the Government of India.

(iii) The officers on completion of 20 years should select either the civil or the military department and should get promotion in their respective departments.

(iv) A separate civil medical service should not be brought into existence as it will lower the standard of recruits both for the Royal Army Medical Corps and the amalgamated service, and by leaving open fewer opportunities for practical work will also impair the professional efficiency of the latter service.

(v) A successful candidate in the competitive examination, held in England, should come out to India and after going through a course of training at an Indian Medical Corps College, should pass a year in military service, then be seconded for 4 years' duty in the civil, on completion of which he should take 6 months' leave combined with 6 months' study leave. After returning from leave he should be posted to military duty for 4 years and be given a year's leave as before. One more tour of duty in the civil and one in the military will bring him to the end of 20 years' service when he should be made to select either

15 February 1919.]

Captain THAKUR.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

the civil or military department for completing the full term of his service.

(vi) There should be no examination for promotion to the majors' rank.

(vii) Male nurses only should be appointed to Indian station hospitals.

(viii) There should be no Home reserve either of nurses or of medical officers.

(ix) The annual allotment made by the Secretary of State for India to the Millbank College should be discontinued and given to the Indian Medical Corps College, which should be situated in one of the places where a first class medical college already exists.

(x) Sepoys should not be appointed ward orderlies. "Kahar" class make very good nursing orderlies.

(Q. 2.) I cannot express an opinion as to whether it will be acceptable to the War Office, but will meet the need of the army in India.

(Q. 3.) Yes by modifying it to suit requirements.

(Q. 4.) So far as the treatment of the sick in the military department is concerned, the patients have not suffered to any marked extent. There has been a good deal of confusion regarding reports and returns but this is inevitable owing to the inexperience of the officers and subordinates employed in the Indian troops' hospitals.

(Q. 5.) Yes and will meet requirements of the war on an extensive scale as the whole of the subordinate medical personnel will be available for professional duties.

(Q. 6.) Yes.

(Q. 7.) Yes. A war on a very big scale would require such reserve. It can be obtained by securing the services of those medical men in India who are not in Government employment. They will be willing if some assurance be given them that they will not be moved out of their district or at any rate their province.

(Q. 8.) The reserve was based on possible requirements for any frontier expeditionary force. The reserve was therefore found to be very inadequate during the present war.

(Q. 9.) (i) Competitive examination as at present.

(ii) The present cadre of the temporary Indian Medical Service contains officers who have earned military distinctions. These officers, as well as others who hold British qualifications and are capable, should be given commissions as to bring the percentage of Indians to 33 per cent. as recommended by the Public Services Commission.

(iii) A certain number of graduates of Indian universities who have passed out with distinction should be given financial help to enable them to appear in the competitive examination in England. They should, however, be made to take a British qualification before competing for the Indian Medical Service. The financial help should be in the form of loans to be realized after their appointment in the service.

(iv) It is probable that Anglo-Indians may not be able to secure higher places in the Indian universities. The principals of various medical colleges should be asked to nominate a few bright Anglo-Indian graduates who should be allowed the same kind of help as mentioned in para. (iii) above.

(v) Military assistant surgeons who have got British qualifications should be given commissions if they are considered suitable.

(Q. 10.) See no. 1, para. (v).

(Q. 11.) A department for research should be created and special rates of pay should be allowed to its members. An officer of the Indian Medical Service may be appointed to it, but in making these appointments none but first-class men should be selected. There should be a probationary period of two years during which if the officer is found unfit he should not be kept in the Research Department. Officers permanently appointed to the Research Department should not ordinarily be available for military duty, but on an officer being found no longer capable of turning out actual scientific research work he should be reverted to any duty for which he is deemed capable, and replaced by one who can do research work. In this connection I wish to draw a sharp distinction between research work *per se* and ordinary administrative and routine laboratory work.

CAPTAIN K. S. THAKUR, I.M.S., called and examined.

(President.) He had 9 years and 6 months' continuous military service but had not yet been in civil employ. He was a Mahratta Brahmin of the Central Provinces. He was educated in Lahore and in England where he had spent 18 months. During the recent war he had served in Egypt for 6 months and also on hospital ships in various waters. After his return to India he served with the Waziristan Field Force. He entered the Indian Medical Service with the idea of going into civil on account of the professional opportunities which that offered. He intended to transfer to civil as early as possible. He was in favour of scheme B with a few alterations. The latter related to the seconding of Royal Army Medical Corps officers. He had no objection to exchanges; for example, supposing there was a unified service, five officers from the unified service could go to England on a temporary exchange and five Royal Army Medical Corps officers could come to India. No permanent transfers should be allowed.

Scheme 'A' he thought excluded Indians altogether.

(General Cree.) He would exclude the Royal Army Medical Corps altogether from India and have a unified service to meet the whole of the civil and military needs of India. He would keep such a service in touch with western military affairs by allowing study leave every four years for 6 months. He considered that would be sufficient for the purpose. He stipulated for alternate periods of 4 years' duty in civil. He did not think it necessary for a man to spend his whole life in military service in order to become a successful military administrator. He would have a portion of such service in the civil. This would give enormous reserves and would be very valuable

from the administrative point of view. No matter to what extent the cadre of the civil medical service should be increased he would have all its officers form part of the military reserve. If there were an Indian Medical Corps and no Royal Army Medical Corps officers in India the whole care of the British army in India would fall to the Indian Medical Corps. He would not hesitate to place Europeans, Indians or Anglo-Indians in charge of a combined station hospital to look after both British and Indian troops. He would employ women nurses for British troops only. There should be no nursing sisters in Indian troops' hospitals.

(General Hehir.) He had never experienced any difficulty in looking after British officers or their families. He had been in charge of British troops in Gallipoli and never had any trouble. They always obeyed orders. He favoured the suggestion to have simultaneous examinations, in India, for selected candidates for the service, and then send them home for two years.

The reason why the military side of the Indian Medical Service had suffered through neglect was because they had not an effective voice in the administration of the Indian military medical department, owing to the Director, Medical Services in India, having always been a non-Indian Medical Service officer.

(General Hendley.) With regard to the financial help which he proposed should be given to a certain number of distinguished graduates in India to enable them to appear in the competitive examinations in England, this might be in the form of loans or scholarships, but should be refundable. The selected candidates would go home for two years after

15 February 1919.]

Captain THAKUR.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

graduating in India. If selected during their college course and sent home to qualify, they would have to stay longer in England, because after qualifying they would have to study special subjects. He thought that the average Indian student would not be able to go up for the competitive Indian Medical Service examination in England, until he had put in 7 years' study altogether. There were some exceptions to this, but the majority, he thought, would need 7 years' study. He had come in contact with several temporary commissioned medical officers but he did not think they had done very well. Professionally, they had not much experience. The majority of them were just qualified and had no military training. He thought they profited very much by their military training and became better officers after a short time. They are not comparable with the Indian Medical Service officer because the training in this country was different.

In reply to a question as to whether he had causes for discontent with the Indian Medical Service the witness said that, as that was a personal question, he would prefer not to answer it. He did not think that any difference should be made between the pay of the European and Indian members of the Indian Medical Service because it would create invidious distinctions.

(Mr. Hignell.) He thought that the chief attractions of the Indian Medical Service in the eyes of Indian students were the opportunity it offered for professional work, and also the emoluments. A purely civil service would give the same prospects in the matter of pay and attract Indians to the same degree. He did not think that Indians in military service attach any importance to the holding of military rank. His objection to scheme A was that officers would come out to India with a very temporary interest in Indian affairs, always looking forward to going Home. The result would be a lack of continuity of work. In the hospitals, an officer starting research work in any subject could only devote 5 years to it, and the work would remain where he had left it. If the Royal Army Medical Corps were thrown open to Indians, he thought a substantial number of them would join the corps, because the standard would be

lower, and the Indian, who would not be able to go to the civil service, would enter the military. By the standard being lower, he alluded to the standard of professional ability, which was of less importance, in the Royal Army Medical Corps than ability for administrative work. With regard to the auxiliary corps, referred to in scheme A, he thought that it would amount to having a civil service side by side with a military one, with its attendant jealousy between the civil and military.

(General Giffard.) If the civil and military medical services of India were separated, the best class of candidates would enter the civil service, while the Royal Army Medical Corps would come next, and the Indian military service last in popularity. He did not completely agree with the suggestion that Indian Medical Service officers in civil employ were practically useless for military administrative posts and the higher military commands. The only deficiency in the senior medical officer was that he did not know enough of ordinary military routine duties, which he could easily learn if he was to revert to military service for a year. If they were taught their business and decided at some particular stage of their career to return to military service, that would solve the difficulty. He saw no objection to the existence of one big medical service that would do all the business of the Government of India. He would not allow those Indians who had been to England to compete indiscriminately for commissions, but would select them. The present procedure was for the Director-General, Indian Medical Service to grant certificates to the effect that the candidates were suitable; but he would not leave this selection in the hands of a single individual. He would favour the idea of a selection board. He did not think a medical officer would prove efficient professionally if he had to remain in military service permanently, because his experience of diseases would be limited to a few.

(General Hehir.) He thought that Indian private practitioners could easily be made to form part of the war reserve, if they were given to understand that they would not be sent out of their province or district. They would thus set free Indian Medical Service officers for military duty.

17 February 1919.]

The Hon'ble Major-General W. R. EDWARDS.

*(The schemes and questions referred to by witnesses are contained in Volume III.)***At Delhi, Monday, 17th February 1919.**

PRESENT :

THE HON'BLE SIR VERNEY LOVETT, K.C.S.I., I.C.S. (*President*).

MAJOR-GENERAL G. CREE, C.B., C.M.G., A.M.S.

MAJOR-GENERAL P. HEHIR, C.B., C.M.G., C.I.E.,
I.M.S.

MAJOR-GENERAL H. HENDLEY, K.H.S., I.M.S.

THE HON'BLE MAJOR-GENERAL G. G. GIFFARD,
C.S.I., I.M.S.

S. R. HIGNELL, Esq., C.I.E., I.C.S.

LIEUTENANT-COLONEL A. SHAIRP, C.M.G., Indian
Army.

LIEUTENANT-COLONEL G. B. A. RIND, Indian Army.

MAJOR A. A. MCNEIGHT, I.M.S. (*Secretary*).THE HON'BLE MAJOR-GENERAL W. R. EDWARDS, C.B., C.M.G., M.D., I.M.S., Director-General, Indian
Medical Service.*Written statement.**(Prepared for the Reforms (Subjects) Committee, and submitted in evidence before the Medical Services Committee.)**Note on the medical services in India.*

I have been called upon to give evidence before the Subjects Committee and have been asked to put up a note on what I wish to say.

I understand that the main heads on which my evidence is required are the following :—

- (1) The question of "provincialisation."
- (2) The question of "transfer."
- (3) Maintenance of services (all Indian and provincial).
- (4) Medical education.
- (5) Research work.
- (6) Inspection by a central agency.

Before proceeding to note on these points, I should like to draw attention to the administrative disabilities from which the medical services of India now suffer, and owing to which their work is very seriously handicapped.

These disabilities are the result of the vast progress which has taken place in medical sciences with no corresponding change or improvement in the administrative machinery.

Years ago when medicine was regarded as a question of pills and potions, and preventive medicine was only dreamed of by a few, the present system may have been an adequate one; it is not so now.

Very few laymen understand or think of the immense potentialities of preventive medicine, and the vast future it has before it. Nor do they appreciate the immense amount of medical work which we are endeavouring to carry on in India in the face of grave difficulties.

I believe that the only important administrative change which has taken place in recent years is the slow and stunted growth of a Sanitary Department and the inception of a Bacteriological Department. But the grave mistake has been made of divorcing these departments from curative medicine, and other medical services, by placing them under the Member for Education. In the provinces this divorce is complete and it was so with the Government of India, until my predecessor appreciating the gravity of the error, succeeded in regaining control of research work, and the Sanitary Commissioner was made subordinate to him. Even so the Director-General of the Indian Medical Service and Medical Adviser to the Government of India, still has to work through two members. In the provinces the Sanitary Commissioner, on account of the separation, has to apply to the administrative medical officer for personnel in case of epidemics, and many officers are partly responsible to the administrative medical officer and

partly to the Sanitary Commissioner. It is impossible for these two departments to work smoothly and efficiently when separated as they are now in the provinces.

Probably very few persons outside the Government of India have any idea of the duties for which the Director-General, Indian Medical Service, is responsible or the size of his office, but regard him as merely the head of the Indian Medical Service. The Director-General's office now numbers five commissioned officers (*plus* one temporary), a ministerial staff of 45 and 32 servants. The duties of the Director-General and his office are as follows :—

The office of the Director-General has relations with nearly every Department of the Government of India, not necessarily through the Home Department, to which it is officially subordinate. The subjects dealt with are numerous and varied.

Home Department.—All questions concerning medical policy and administration; matters pertaining to medical personnel, both superior and subordinate, in civil employ, medical questions concerning the Prisons Department, hospitals and dispensaries, the Alienist Department, medical registration, the X-Ray Institute, the Chemical Examiners' Department, etc.

Education Department.—All sanitary questions, the maintenance of the Bacteriological Department and the various scientific problems dealt with in the Pasteur and Research Institutes. The work of the Scientific Advisory Board, Indian Research Fund Association (of which Director-General is the President) including the publication of the Indian Journal of Medical Research.

Foreign and Political Department.—The Director-General is the sole medical adviser (there being no Inspector-General of Civil Hospitals under this Department) and the office has to deal with all questions of appointments, transfers, and selection of medical officers, for the various residency surcoucies. Also all matters connected with the medical arrangements for Imperial service troops and important sanitary questions that arise in Native States.

Army Department.—All cadre questions such as recruitment, promotion, and special selections in the Indian Medical Service and Indian Medical Department. The education of military medical pupils both for the assistant surgeon and sub-assistant surgeon class. Responsibility for the whole of the medical store department and the supply of vaccines and medical and veterinary equipment for the army, both in peace and war, also the mobilisation of civil medical officers and subordinates who form the army reserve.

17 February 1919.]

The Hon'ble Major-General W. R. EDWARDS.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

Revenue and Agriculture Department.—Questions concerning the quinine policy of Government; many abstruse entomological questions in connection with work at Pusa, where a strict line of demarcation between medical and pathological problems is not possible. Various questions concerning future development in the direction of utilising the enormous untapped resources of Indian forests, in the way of medicinal plants from which drugs can, and should, be manufactured in India.

The Director-General is also a member of the Board of Scientific Advice.

Commerce and Industry Department.—Questions concerning food and drugs especially where morphia and cocaine are concerned; questions dealing with the export of certain classes of articles to the United Kingdom and foreign countries.

The Director-General is the medical adviser to the Railway Board.

This office has direct communications with the offices of the Director, Medical Services in India and the Quartermaster-General, Director, Central Intelligence, also with the Indian Munitions Board. Other Departments, such as the Public Works Department, ask for advice.

The above is a trifle compared with what ought to be done.

(1) An enormous expansion should take place in the medical store department relative to the manufacture of drugs from indigenous products, so as to make India as self-supporting as possible. With regard to this please see Appendix I.

(2) Research. Before the war began, we had some 40 officers engaged on original medical research.

I hope to see an enormous expansion in the facilities for this work and a still further increase of personnel. Our research workers have at present the gravest difficulty in securing trained assistance. The future of medical research is of the utmost importance to the human race, and what has recently been discovered is nothing compared with what it is hoped will be discovered. In this most beneficent work of worldwide importance India must take a forward place.

India in this respect owes a great debt of gratitude to the late Sir Pardey Lukis and to Sir Harcourt Butler, who between them founded the Indian Research Association, towards the work of which the Government of India have given five lakhs a year. I may add that medical research, if efficiently conducted, should add immensely to both the health and wealth of India.

(3) Preventive medicine now in its infancy should be zealously guarded and fostered by the Government of India. It is in this direction that the great future of medicine lies. Medical research is far ahead of applied preventive medicine because up to the present time in India, Government has not paid sufficient attention to the diffusion, and the application of, the knowledge that has been so laboriously acquired. Government has grasped the necessity of hospitals for curing sick people, but has not secured the means of spreading the knowledge whereby such a vast amount of sickness can be prevented. Precautions, that should be well known by the people, can enormously lessen the incidence of such diseases as plague, tuberculosis, malaria, cholera, dysentery, typhus, enteric, hookworm, all zymotic diseases, puerperal fever, beri-beri, scurvy, and many other deadly complaints. We hope to discover the causes of, and devise means for, avoiding a number of other diseases, such as say, dental caries, pyrrhoea, diabetes, influenza, sprue, cancer, leprosy and kala azar, on which diseases much work is being done. The subject has enormous possibilities and the ignorance of the layman concerning these matters, both in the upper and lower walks of life, is abysmal. It is on this account that the education of the masses is of such vital importance, and until Public Health is systematically taught throughout every school in India, and well taught, the Public Health Service will practically labour in vain. At last in England, they propose having a ministry of public health. There is no reason why we should not have one in India, but on the contrary the strongest reason that we should. In this case public health including the medical services gene-

rally could well be coupled with education, for it is only as I have pointed out, through the education of the masses, that the science of public health can become a practical policy.

What do we find in India? The medical department is considered of such little importance that it is actually split up, part of it being attached to the Home Department and part to the Education Department. Its office, of necessity a very large one, is, both at headquarters and in the provinces, regarded as an attached office.

Our clerks are less well paid than those of any office of the secretariat, and are in consequence not regarded as of the same standing as men in the secretariat. The head of the office is not granted gazetted rank, as a right although the heads, as well as superintendents of sections, of all secretariat offices are granted it and the heads of army offices ordinarily hold commissioned rank or else are gazetted officers. The Director-General, the head of the department and Medical Adviser to the Government of India, has not the right to see His Excellency the Viceroy officially unless sent for. Indeed it might so happen that his opinion on any subject should not be asked for by the departments dealing with medical matters, and if asked for it may be ignored.

It, therefore, seems to me that there should be no question of considering the "Transfer" of medical subjects until at least they are put on a sound footing with the Government of India. To effect this I make the following proposals:—

(1) All medical subjects should be placed under one Member of Council. He should be known as the Member for Public Health and Education.

(2) The Medical Adviser to the Government of India, the Director-General, Indian Medical Service, as he is now, should be granted the official right of seeing the Viceroy by applying direct to his Private Secretary; he should have the status of a Secretary to Government.

I may mention here that though I believe most Surgeons-General and Inspectors-General of provinces have access to Governors and Lieutenant-Governors of provinces, a privilege which I consider of the utmost importance, both to them and to the Government of the provinces, yet I understand that this is not an official right.

(3) His office should be organised on the same basis as to pay and appointments as secretariat offices.

(4) The head of the medical department should be President of an Imperial Health Board (*see* Appendix II) to which all questions that he, or the member in charge, considers of sufficient importance be referred; when necessary, professional questions may be referred from this Board to an Advisory Board in England attached to the India Office. Similarly questions might be referred from Provincial Health Boards to the Imperial Health Board.

Again, it is absolutely necessary to co-ordinate the work of various medical departments, and it is impossible to find one head to such a vastly important and varied department, as the medical department now is, who can advise on all subjects.

For this reason not only should the proposed Boards be instituted, but they must have the power of co-opting members as necessity arises. For instance, it might be found necessary to co-opt an alienist, or the Principal of a College, or Director of a Research Institute, and so on, in order to discuss special subjects. This question of Medical Boards is a very important one; it was debated on at the Conference of Public Health and Research officers in Delhi last December, and the necessity for such Boards was unanimously agreed upon.

(5) A Director of Medical Research must be appointed. This is an important matter and if medical research is to be prosecuted as it should be in India, it is a very essential appointment. The Medical Conference of last December were unanimous on this point.

I lay great stress on this appointment because I consider that the medical research service, which should have a splendid future before it, cannot be efficiently conducted without a Director of its own. Research is a very specialised subject and the Research Department must, in future, be organised and supervised by a care-

17 February 1919.]

The Hon'ble Major-General W. R. EDWARDS.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

fully selected specialist in this subject, with wide experience.

Having cleared the ground to some extent, I now come to the question of the Transfer Subjects Committee.

(1) Devolution of authority from the Imperial Government to the provinces.

This as regards medical matters is practically complete and in some cases has gone, I think, too far. I think that all administrative appointments of officers of commissioned rank such as Inspectors-General of Prisons, Sanitary Commissioners and Professors, should in every case be referred to the Government of India, before they are made. This is only fair to the Indian Medical Service, and I wish it done in order that junior officers may not get prize appointments, when senior officers, equally, or better qualified, may be available in another province.

I would here call attention to the fact, that not only are officers of commissioned rank peculiarly suited for many administrative appointments but, in future as in the past, we now have reason to believe that the Indian Medical Service will be recruited from among the best men of the medical schools, and further it is understood that in future 33 per cent. of the appointments may be granted to Indians who are proved to be sufficiently well qualified.

II. The question of "Transfer"—I am opposed to any medical authority being taken from the provincial member in charge of the medical department, for in my opinion it would certainly lead to inefficiency. To begin with I understand that, if medicine is a transferred subject, it is proposed to break up the Provincial Medical Services, on the plea that those who directly pay for an appointment should have complete power in selecting, removing, or punishing, the man who fills the appointment. This is all very well in private companies but not so in State appointments. I shall endeavour to show the drawbacks. There are certain inestimable advantages in a medical service.

(1) There is a continuous chain of authority from the highest to the lowest.

(2) It is of the utmost importance that a medical officer should be free to do his work, and to give his opinion, impartially, and without bias.

It is well known in the provinces that non-service men, taken into dispensaries, or health appointments, have in every way to propitiate, not the men who pay for them, but the few men of the District or Municipal Board, who have power over them.

For instance, it is well known that free treatment at their houses, and free drugs from the dispensaries, are commonly demanded by members of District Boards and Municipalities, and that Health Officers dare not proceed against, or report adversely on, men who have power over them, for fear of getting into trouble. In a Provincial Medical Service any complaints made against a medical man belonging to the service, is at once investigated by his superior officer, who is an expert, and the man himself having the right of appeal, is in a far stronger and more secure position than he would be if not in a service. Departmentally he can be transferred, punished in other ways, or in extreme cases be dismissed from the service, and another man can be found at once to replace him.

(3) Men in a service know that their careers depend on their work and behaviour, and have always something to look forward to.

(4) Men are willing when junior to accept bad appointments knowing that they will be moved on to better ones if they do their best.

(5) In epidemics and famine, the controlling officer knows where to find personnel that can be trusted, and who will be found efficient.

(6) In war time again, such services act as a valuable reserve, and the administrative officer knows whom to take and whom to leave.

(7) A service always contains a leave reserve; this prevents work being dislocated when men go on leave, and

another great advantage is that in an emergency, such as an epidemic or a war, all men can be recalled from leave.

Lastly, in Bengal we had both classes of doctors, service and private, filling District and Municipal Board appointments. As Surgeon-General of Bengal I saw the results of both systems and I have no hesitation whatever in saying that the service system produced far the best results, and was vastly preferred by the holders of appointments. On this account I strongly advocate the retention and extension of Provincial Medical Services.

III. As regards the Indian Medical Service, this is a military service of exceptionally well qualified men. The appointments filled by members of this service, who are in civil employ, must continue to be filled by them as heretofore, in order that the service may have a reserve of highly trained military medical men ready at a moment's notice.

Only 422 men have civil appointments, some 33 per cent. of whom may, it is understood, shortly be Indians. This number of appointments, in a country the size of British India, is extraordinarily small. The men allotted to each province are under the Provincial Government while there, and as they belong to an Imperial and military service the appointments filled by them must be "Reserved appointments." If medicine becomes a transferred subject, the appointing of all medical men in the provinces, including all civil surgeons, will be in the hands of a Minister who can override the suggestions of the administrative medical officer, even if backed with the opinion of an Advisory Board. It is a very serious matter putting such power entirely into one man's hands. Therefore, I would strongly insist that in the case of all medical appointments, the medical authority should have the power of appeal to the Governor of the province, who should be responsible to the Government of India for the efficient filling of all medical appointments, which are not in the gift of the Government of India.

As regards Indian Medical Service cadre appointments, any diminution or increase in the number of these appointments will presumably always be referred to the Secretary of State as heretofore; this I think should be made clear. The value of having a commissioned medical officer in medical charge of a district, of the jail, and of medico-legal cases, is too well recognised for it to be necessary for me to enlarge upon it.

IV. Medical Education both in colleges and schools must be reserved. It is very important that the teaching of so-called western medicine should be kept at a high level and not tampered with. The conduct of examinations must most certainly remain under Government control. If not closely supervised and kept up to the mark, the General Medical Council of Great Britain will at once cease to recognise the degrees of Indian Universities. A certain number of professorships have been reserved for commissioned officers and so long as commissioned officers are found fit to fill these appointments they should have them. They are especially fitted to maintain discipline and thanks to leave, and study leave, they are able to keep themselves abreast of modern medicine and surgery in a way that private practitioners, who do not leave the country, are unable to do. Also the knowledge that these appointments are available for commissioned officers, induces the best class of men to join the service and to fit themselves for these duties.

Many more schools and colleges are required, and such schools and colleges should be staffed by Indians; in addition to this when more professors are required, owing to the growth of State colleges, such appointments can be filled by Indians who are not in the service.

I wish it to be constantly remembered that Indian Medical Service is not synonymous with European. Indian Medical Service officers are Indian, as well as European.

The control of Medical Councils of Registration and of Medical Faculties should remain in the hands of Government. This is important as it is of the utmost import-

17 February 1919.]

The Hon'ble Major-General W. R. EDWARDS.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

ance that no irregularity should occur in the Register. On this account the power behind the Provincial Medical Council of Registration should be the highest in the land.

V. *Research*.—This affects all India and must be kept Imperial. Men doing research work can be lent to the provinces as heretofore. The appointments are open to the best men available, either European or Indian. As regards this service I have already said enough to show the immense importance I attach to it.

VI. *Inspection by a Central Agency*.—I have no hesitation in saying that the inspections as at present carried out by the Director-General, Indian Medical Service, and the Sanitary Commissioner with the Government of

India, should be continued. They are welcomed by the Provinces and are productive of nothing but good.

I hope soon that a Director of Medical Research will also be visiting the provinces. I am also strongly in favour of medical conferences; we cannot do too much to aid the work of co-ordination. Each province has some thing to learn from every other province and the more the administrative medical officers of the provinces are brought in touch with each other the better.

Finally I can only say that whatever is to be the future of medicine in India, I sincerely trust that it may be progressive, and to this end I trust that the recommendations I have embodied in these notes may be accepted.

APPENDIX I.

WORK NOW DONE AT GOVERNMENT MEDICAL STORES DEPOTS.

The Director-General, Indian Medical Service, is, in conjunction with the Director, Medical Services in India, responsible for the equipment and supply of all military medical stores, and with the Quartermaster-General in India for military veterinary medical stores.

He is also responsible for the supply of medical stores to Government and Government aided institutions (both Medical and Veterinary) on the civil side, and for the X-Ray equipment required for both military and Government civil hospitals. In addition, since the outbreak of war, the supply of artificial limbs to disabled soldiers, dental equipment to army dentists throughout India, the manufacture and provision of certain equipment for orthopædic institutions has devolved on the medical stores department.

He also, at the request of other Government departments, assists in procuring or manufacturing a great variety of articles urgently required for war purposes, which cannot, strictly speaking, be adjudged as coming under the nomenclature of medical supplies.

The stores required are obtained :—

- (1) By importation through the India Office.
- (2) From other Government departments, such as Supply and Transport Corps, Military Works Department, Revenue and Agricultural Department, etc.
- (3) By purchase from business firms and contractors in India.
- (4) By manufacture at medical store depots.

For storage, manufacture, and distribution, there are five Government medical store depots, *viz.*, at Calcutta, Lahore Cantonment, Madras, Bombay and Rangoon, under the control of the Director-General, Indian Medical Service; of these, the depots at Lahore Cantonment, Madras and Bombay are manufacturing, as well as supply depots, those at Calcutta and Rangoon being mainly supply depots.

Each of these depots is in charge of an Indian Medical Service officer, who is known as the medical storekeeper to Government, and it is customary for officers once appointed to the medical stores department to remain in this department throughout most of their service.

Medical store depots also undertake the repair of surgical instruments, etc., returned by both civil and military institutions.

Prior to the outbreak of war, the medical stores department was manufacturing pharmaceutical preparations to a considerable extent, and the fact that it was in a position to do so, has been of material assistance in meeting the greatly increased demands, not only from military hospitals in India, but from overseas forces.

Prior to the arrival of a British base medical depot at Bombay in January 1917, we were responsible for the supply of all the medical and surgical stores required by the army in Mesopotamia, and still continue largely to supplement the requirements of this depot, in addition to supplying all articles coming under the heading of Indian pattern field medical Equipment.

We have equipped all general hospitals, field ambulances, clearing and stationary hospitals, advanced depots of medical stores, sanitary and X-Ray sections to meet the demands, both for the army in India, and for overseas forces, as from time to time required by the military authorities.

In addition to meeting all the requirements of Government and State aided civil medical and various other civil institutions throughout India, medical store depots have, from August 1914 to August 1918, met war demands for medical stores required for various theatres to the value of Rs. 79,92,951.

Force " A "	2,29,631
Force " B "	2,64,984
Force " D "	42,78,083
Force " E "	1,59,922
Force " G "	3,399
Persia and Oman	1,52,178
Aden operations	1,23,174
North-West Frontier operations	1,36,323
No. 11, Base Depot Medical Stores, Bombay, for Force " D "	13,02,581
Labour corps	40,713
Ambulance trains	79,891
Admiralty vessels	35,081
War hospitals	5,81,237
Enteric and convalescent depots	24,842
Nepalese contingents	32,273
Territorials	35,358
Hospital ships chartered by the Admiralty	51,364
Prisoners of War Camps	40,524
Other unallocated charges	4,21,893
TOTAL	79,92,951

The strain of war has led to a great development in the utilization of Indian resources in the provision for drugs, medicines, and other materials not only to provide for the requirements of hospitals in India both military and civil, but also for overseas forces. It was recognised that many articles formerly imported could, and should be manufactured in India.

Additional analytical chemists are now working at the manufacturing medical store depots at Madras, Bombay and Lahore, and many preparations are being manufactured at these depots from indigenous raw materials which were before the war imported from Home. In order to relieve, as far as possible, the strain on Home resources and to economise in freight, every effort has been made to develop the manufacture of surgical dressings at our depots, and at the same time, to encourage reliable private firms to extend their output in this direction. Our efforts have been most successful and have, undoubtedly, effected a considerable saving to Government especially in the local purchase of cotton wool, gauze, lint, etc., the prices of which in the English market have advanced roughly 400 per cent. since 1914.

17 February 1919.]

The Hon'ble Major-General W. R. EDWARDS.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

The absolute necessity of securing the correct percentage of medication and complete sterilization have made it essential that orders for the manufacture of these articles should only be placed with firms whose reliability has been fully ascertained. Private enterprise is now largely responsible for the supply to us of absorbent cotton of good quality, lint, gauze, etc., and in addition, it has been utilized in supplementing the supply of medicated and compressed dressings.

The Indian medical stores department is a very large purchaser of surgical instruments and appliances, of which an important source of supply for many years has been the workshops at the medical store depot, Bombay. Part of these premises has been handed over to a private concern which has established in it a factory that provides a considerable portion of the requirements of the department. It employs several hundred workmen who have been trained to manufacture and repair instruments and appliances, and the articles turned out are of excellent workmanship and finish, comparing favourably with articles manufactured by the best known surgical instrument makers at Home. War demands have led to many new developments including the manufacture of shaped artificial limbs and orthopaedic appliances, and all the artificial limbs supplied to the wounded returning from overseas have been manufactured in this factory.

The question of the possibility of obtaining supplies of Indian made glassware for laboratories early engaged our attention, and in 1917 we succeeded in obtaining such articles as petri dishes, Litre flasks, glass tubing and test tubes of reasonable good quality made by the Upper India Glass Works, Ambala City. As we are importers of large quantities of different descriptions of glassware, we suggested in September 1917 that the question of glass manufacture in India should be taken up by either the Department of Commerce and Industry or by the Indian Munitions Board. In this direction much has been done with the assistance of the Munitions Board, and considerable orders have been and are now being placed with several manufacturing firms in India. Among these are :—

The Upper India Glass Works, Ambala.
Bijhoy Glass Works.
Allahabad Glass Works, Naini.
Scientific Glass Works, Allahabad.

There is little doubt that every encouragement should be given to firms in India who are willing to undertake the manufacture of glassware and eventually, it is hoped, that most of our requirements in this direction will be manufactured in India.

The medical stores department imports large quantities of various rubber goods and owing to their perishable nature a considerable loss is incurred. We are endeavouring to arrange for the manufacture of as many of these as possible, and a large range of samples has been sent to a firm of rubber manufactures lately established in Ceylon, Messrs. Addersmith & Co.

We are also large consumers of enamelled iron articles and samples have been submitted to Messrs. Heatley & Co., Calcutta, who are undertaking the manufacture as soon as the necessary machinery is obtained from Home.

The question of ascertaining what raw materials are, or can be made available in India and the best methods of obtaining supplies, both for immediate requirements and with a view to future developments, has been a subject of close investigation by this office for some time. It is an undoubted fact that up to now the indigenous resources of India have not been utilized to anything like the extent possible. Our practice, prior to the outbreak of war, was to purchase in England through the medium of the India Office not only manufactured drugs, but also most of the raw materials required for the manufacture of pharmaceutical products, most of which raw materials had actually been exported to England from India. As examples of this, sandal wood was exported as wood and returned in the form of oil. We have now arranged to manufacture our total requirements of sandal wood oil at the medical store depots.

Myrobalams sent Home returned as tannic acid. We now manufacture all our requirements.

Nux vomica beans were sent to England and returned as the powder and as extract, and in the form of strychnine. We are now manufacturing all our requirements of the two former, and our chemists are investigating the possibility of the manufacture of strychnine from nux vomica beans.

Potash salts existing in India were never utilized in making potassium carbonate, bicarbonate, acetate, citrate, cyanide, red and yellow prussiate, etc. All these are now being made by private firms in India.

Ajwan seeds were formerly exported to Germany and returned to India as thymol. We now manufacture our total requirements, and several firms are manufacturing thymol of good quality on a large scale. These firms should be assisted to get in touch with buyers in England as there are great possibilities of a lucrative export trade with England.

The general investigation as to the possibilities of obtaining Indian grown products has for some time back occupied our attention, and in December 1917 this office drew up and submitted a note to the Revenue and Agriculture Department pointing out the desirability of taking up the question of the cultivation of medicinal trees and plants. This has led to the proposal that a Committee should be formed to deal with the subject. So far, the information available, merely, as it were, touches the fringe of possibilities and owing to the almost complete lack of data in the form of any up-to-date literature and reliable information on the subject, the problem is an extremely difficult one. Many of the medicinal plants required grow wild in Indian forests, and owing to the hitherto small demands are classified as minor forest produce, and no special attention appears to have been paid to them nor does there exist, as far as is known, any effective organization for collection. In the first place, it would appear desirable that a survey should be undertaken to ascertain what medicinal plants grow wild in the forests, where such plants grow most freely, and are most accessible for collection. Such a survey would assist in supplying Government's requirements, and those of private firms, possibly creating a lucrative export trade in the future. This undertaking could only be carried out thoroughly by the Forest Department and the Botanical Survey.

Articles such as cinnamon, cloves, senna, castor oil seeds and various others of every day consumption known to grow, and be available in large quantities in India, need not be considered.

Our efforts have been concentrated chiefly in the direction of obtaining satisfactory and regular supplies to meet our own requirements, but inquiries have opened up the larger question of the possibility of creating a considerable and valuable export trade from India, thereby assisting in making the Empire self-supporting as regards a number of products formerly obtained from enemy countries.

There can be little doubt that markets would be available, as private firms in India have been and are now exporting to Great Britain, America and other countries Indian grown drugs, which these countries formerly obtained elsewhere. The demand exists and the problem to be overcome is mainly that of organising cultivation and collection also reduction of railway freights on such products over long distances, the latter as a temporary measure until information is obtainable as to what rail tariffs such products can reasonably bear, to allow competition with other sources of supply outside India. The high rail freights from sources of supply to the sea ports of manufacturing centres in India, permitted Germany and other producing countries, in many instances, to cultivate, collect, ship to London, and re-ship to India at prices which were actually lower than indigenous products could be made available at Indian Sea-Ports.

To exemplify this, take the case of belladonna. This root was grown in Germany, collected, dried, packed, shipped to London, paying one or two middlemen's profits there, re-shipped to India, duty paid on entry, and

17 February 1919.]

The Hon'ble Major-General W. R. EDWARDS.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

purchased in India at Rs. 40 per cwt. The cost of collection, royalty (in the case of private firms) and rail freights to Calcutta or Bombay, made it impossible for Indian grown belladonna to compete. In 1916 we received a communication from the Secretary of State that our demands for belladonna could not be complied with; upon which we got into communication with the Superintendent of the Government Gardens at Kumaun and asked him to lay down five acres under belladonna cultivation, the resulting crop being earmarked to meet our requirements. We have since obtained our total requirements of both belladonna roots and leaves of most excellent quality from him, and although we have purchased considerably under the ruling market rates, he has found the cultivation a very profitable undertaking.

Again, in the case of digitalis, we have been able to obtain our total requirements from Bengal, and the Kumaun Gardens have been asked to place a sufficient area under cultivation to enable them to meet our future demands.

We are aware of various other valuable medicinal plants, growing wild in large quantities in the Indian forests, but until an organised survey is undertaken, the problem of collection and utilization of these products cannot be satisfactorily solved.

A large number of articles which were, prior to the war, imported are now either being manufactured at our medical store depots, or experiments as to the possibility of manufacture have been undertaken. Among these are the following:—

We manufacture our total requirements of—

1. Absolute alcohol from rectified spirit.
2. Amylum, B, P (Starch) from rice.
3. All belladonna preparations (from Indian grown belladonna).
4. Digitalis preparations, formerly manufactured from imported leaves, now made from Indian leaves.
5. Lysol from saponified cresol.
6. Ferri sulphas from iron filings (foundry waste) and sulphuric acid.
7. Thymol, B, P, from ajwan seeds.
8. Nux vomica preparations from Indian seeds.
9. Tannic acid from myrobalams.
10. Silver nitrate sticks from Indian made silver nitrate crystals.
11. Various mercurial, B, P, preparations.
12. Oxymal scilla, B, P, from honey and squills. The latter being obtained from the beach at Salsette outside Bombay.
13. Chaulmoogra oil.
14. Collodium flexile.
15. Sodii sulph. exsiccatus.
16. Aloe, B, P.
17. Calcium carbonate precipitated.
18. The extracts of cascara, colocynth, glycyrrhiza, hyoseyami, belladonna, nux vomica, gentian.
19. Glucose from starch.
20. Essential oils; anethi, anisi, cloves, cinnamon, croton, myristica, theobromine.
21. Iodine powder.
22. Liquor bismuthi et ammon citras.
23. Magnesii carbonas.
24. Oleic acid.
25. Pyroxyllinum.
26. Sodii nitris.
27. Sodii sulphas.
28. Sodium chloride, pure.
29. Syrupus ferri phosphatis co.
30. Acid. sulphuric, normal solution.
31. Rectified alcohol.
32. Cedar wood oil.

All the above are new preparations which were formerly imported.

In addition to these, our chemists have succeeded in making:—

1. Anaesthetic aether, B, P, of which we hope to be in a position to make our total require-

ments when we have had time to test its keeping properties.

2. Boric acid from crude borax. The manufacture of this will not pay commercially until the crude borax coming into India from Nepal and Thibet, is either subject to a considerably lower tariff to make it available at the sea ports at a much cheaper rate, or something in the way of a small factory started in the Himalayas at some such place as Kotgarh in the Simla hills. Large quantities of crude borax, in transit to India from Thibet, passes through Kotgarh and the refining of crude borax is an extremely simple method which does not necessitate the provision of any special machinery. At present the crude borax which is carried to Bombay, Madras and Calcutta contains roughly 30 per cent. impurities which could readily be extracted.

3. We are also experimenting with the manufacture of the alkaloids, atropine, emetine, strychnine, calcium chloride, magnesia potassii acetat, potassii permanganas, soft and hard soap, refined glycerine, also the manufacture of an insect powder, as effective as the well known Keating's Powder.

Our depots are now making almost all the pharmaceutical preparations required, including tablets, pills, extracts, tinctures, liniments, liquors, unguents, powders, etc., many of which are new preparations, formerly imported, which we have lately undertaken the manufacture of.

It is not feasible in this note to give full details of everything we are manufacturing, but among these are included:—

- Codeine tablets.
- Borated talc powder.
- Carron oil.
- Medicated vaseline.

Our depots also are manufacturing all Government's requirements of castor oil, arachis oil, from Indian grown seeds. Oxygen is compressed in cylinders for issue to hospitals.

At Madras, we are making first field dressings for the use of the army at the rate of 1,000 per diem.

The Indian Institute of Science at Bangalore supplies us with:—

- Ethyl chloride.
- Calcium chloride.
- Calcium lactate.
- Sodium acetate.
- Aniline oil.
- Lactose.

Our bandages are obtained from Indian jails, wool cotton absorbent from Messrs. Sassoan & Co., Bombay, and Messrs. Andrew Yule & Co., Calcutta. Cottons and gauzes, medicated and compressed, from private firms in India.

Oil of turpentine and resin from the Forest Department.

Liquor ammonia fortis, lycopodium, acid sulphuric, B, P, acid hydrochloric, B, P, acid nitric, B, P, the various medicinal potash salts from private firms in India, which manufacture them.

Operation room furniture, water bottles, brass pestles and mortars, basins, aluminium measures, formerly imported, are now obtained from manufacturing firms in India.

Trial orders for various description of surgical instruments have been placed with Indian firms.

Although during the war, it was essential that Government's requirements should, as far as possible, be manufactured by us, it will be necessary to consider whether the Government medical stores department should continue to manufacture articles which reliable private firms are also manufacturing in sufficient quantities in India from Indian raw materials.

17 February 1919.]

The Hon'ble Major-General W. R. EDWARDS.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

It is unfortunately true that in India up to now, the difference between samples submitted and actual supplies subsequently delivered, is liable to be considerable and until trial orders have been placed and deliveries have proved up to the standard required, it has been and will be very necessary to exercise the greatest caution in placing orders only with firms whose reliability is assured. Another difficulty experienced, more particularly with the smaller firms, is that in their anxiety to obtain contracts, they undertake more than they can safely guarantee and break down as regards delivery within the period contracted for. They are also prone to quote terms, which in practice, they are unable to carry

out, without either suffering heavy loss or being forced to ask for a revision of rates owing to fluctuations in the markets.

In dealing with the purchase of drugs, surgical dressings, and instruments, the question of quality is so important that our best policy is not to place reliance on doubtful resources of supplies. It is essential that we should not discontinue any manufacture, until the output by reliable commercial firms has been established on a sufficiently large scale as to render it absolutely certain that Government will be able to obtain all its requirements without difficulty, and at prices comparing favourably with our cost production.

APPENDIX II.

With the growth of medical sciences, particularly that of preventive medicine, and medical research, and the vastly increased importance which the health and well being of the people has taken, in the eyes of Governments, the necessity for the improvement of medical organization has become imperative.

It is generally felt by medical men, that one of the best measures for achieving this object would be the institution, in India, of Medical Advisory Boards of Health; such Boards, Provincial as well as Imperial, would consist of experts in various lines.

The Medical Adviser to the Government would be the President of the Board in each case, and would have the status of a Secretary to Government. Permanent members of the Imperial Health Board would be the Director of Medical Services, the Sanitary Commissioner, and the Director of Medical Research. The Deputy Director-General would be Secretary.

Other members such as Alienists, Inspectors-General of Prisons, Directors of Research Laboratories and Professors, would be co-opted as necessity arose.

In the provinces, the permanent members might con-

sist of the Sanitary Commissioner, a representative of the Medical Council of Registration, the Inspector-General of Prisons and a representative of Medical Research. As before other members would be co-opted as required.

All questions of general policy affecting medical education, sanitation, research work and cognate subjects would come before these boards, and also any questions which the Member in charge of the Department, or the Administrative Medical Officer, desired to place before the Board. Where there was any doubt as to the selection of a candidate for a medical appointment, the claims of the various candidates should be submitted to this Board for consideration.

The findings of these Boards would then be submitted for the consideration of the Secretaries concerned, and finally placed before the Member in charge. Should he refuse to accept the findings of the Board, the Board should be officially informed, and the President should then have an opportunity of discussing the matter with the Member in charge, and if he considered it necessary, of speaking to the Governor of the province or the Viceroy.

MAJOR-GENERAL EDWARDS, called and examined.

(President.) He was in favour of schemes B and C taken together, but there were two points which he considered essential, firstly that there cannot be an Imperial civil medical service separate from the military service, and secondly that there must be an exchange of officers between military and civil employ. If officers are not transferred from the military to the civil, the Imperial civil service would disappear and the provincial medical services would take its place. He was in favour of one medical service to fulfil all the requirements of the British Army in India and the Indian Army, and a portion of the civil requirements; but this service could not undertake more civil duties than those which the present Indian Medical Service performs. The civil medical needs of India were very great, and the officers of the Indian Medical Service in civil employ were but a small part of the service ministering to these requirements.

He would, in the first instance, second into the new service. The next question was whether such seconded officers were to be allowed to transfer to the Indian Medical Corps. If so, they would soon fill up the Indian Medical Corps and there would be no longer any need to second Royal Army Medical Corps officers to it. Under these circumstances it would soon result that there would be no Royal Army Medical Corps officers serving in India; but on the other hand, it might be ruled that seconded Royal Army Medical Corps officers were not to be allowed to transfer to the Indian Medical Corps, in which case the presence of the Royal Army Medical Corps in India would continue.

In order to meet the civil medical needs of the country, Indian Medical Corps officers would hold a

certain number of civil appointments in the provincial services, as at present, the remaining appointments, as at present, being filled by officers recruited by the local government.

(President.) The Research Department would be under the new service. His idea was to have a Ministry of Health, with the heads of the various departments forming a board. He had elaborated that in his written statement.

The Director General, Indian Medical Service, as Medical Adviser to the Government of India, would be the nominal head of the civil side under a Member of Council. The Director, Medical Services in India, would be the executive head of the military portion of the service, under the Commander-in-Chief, also a Member of Council. This might be said to constitute a Diarchy, but it worked well at present and without friction, and he could see no escape from it.

The Director General had no executive control over officers in military employ.

Except for the necessity of maintaining a reserve for the army in civil employ, it would be difficult to establish the need for an Imperial civil medical service as the work could be done by the provincial services.

With regard to the question of recruitment, he did not think they would get European recruits, for a separate civil medical service, unless they were paid excessively.

He thought the best way to manage the medical affairs of India was by Boards. There would be the

17 February 1919.]

The Hon'ble Major-General W. R. EDWARDS.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

President of the Board and the members. The Director, Medical Services, would be a member. Subjects for arbitration would be discussed before the Board and put up before the Member of Council in charge, who could discuss it with the President and if they could not settle it, it could go to the Viceroy, and, also, if necessary, to the Secretary of State. The Director General, Indian Medical Service, would be president of the Board. He is more or less the arbitrator now, and the witness would not advocate a change in the present system.

(President.) He would not alter the system so far as the Director General and Director, Medical Services, are concerned. His scheme was almost precisely the same as existed at present. The Director, Medical Services, looked after the whole of the military requirements of the country, Indian and British, and he would do so in future, but he would not have anything to do with the civil. He (the witness) would put the two services they had at present into one service, and call it one service. From his point of view it would make no difference to the Director General or Director, Medical Services, whether there was one service or two; but there would be less friction with one service. It would make no difference to the civil side. At present the Director General was nominally the head of the Indian Medical Service, but his military men go to the Director, Medical Services, and so they would in future. His civil men were allotted to the provinces.

He contemplated one service to look after the medical needs of the Indian Army, the medical needs of the British Army in India, and the medical needs of the civil population in so far as these latter came within the province of the Director General, Indian Medical Service. He explained that the Surgeons-General and Inspectors General of each presidency and province had very large powers of their own with which the Director General, Indian Medical Service did not interfere in any way. He (the witness) was the head of the Indian Medical Service, of which a certain number of officers filled civil appointments; but the civil appointments filled by these officers only contained a few of the civil appointments in each province and in future will be still less. This was the point he wished to make clear. 422 civil appointments in connection with the needs of a population of over three hundred million people were filled by Indian Medical Service officers.

The provincial services must not be regarded as entirely subordinate. Many assistant surgeons hold civil surgeoncies which are superior appointments and independent charges.

(General Giffard.) He contemplated that, when the civil needs of India outgrew the size of the present civil Indian Medical Service, there would grow up in India a civil medical service or a number of civil services which would be under provincial administrations. The medical needs of the whole of India could not possibly be catered for by one service. It was the provincial service that would grow and expand in each province.

The strength of Indian Medical Service officers in civil employ would be distributed according to the needs of the provinces. Each province would have to fix its own cadre from time to time according to its needs and its wealth. The number in different provinces varied enormously at the present time.

In order to meet the demands of the families of European officers in civil stations and of European civil officers for medical treatment by men of their own race so as to offset the fact of the service becoming more and more Indianised, he would lay down a rule that a definite proportion of European officers must be maintained in the Indian Medical Corps, and that there should also be a certain number of European civil surgeons in each province.

(General Cree.) The chief reason that there were Indian Medical Service officers in civil employ was that this was the most satisfactory and economical way of employing the reserve required for the army.

Another, though less important reason, lay in the necessity for providing European medical officers to look after European government servants.

With regard to scheme A the principal objection was that the proposed auxiliary corps would not meet the political aspirations of Indians. He agreed that, if the ranks of the Royal Army Medical Corps were opened to all British subjects, irrespective of race, this scheme would meet the aspirations of the Indian. If, however, the Indian was liable for service in any part of the British Empire, it would act as a deterrent to Indians entering the service. It would be an advantage to the Indian not to have to serve out of his own country; but whether the idea would be feasible, without causing friction, was doubtful. He would not, however, favour service on any such terms. If there was to be an Imperial Medical Service, all the members of that service must be available for service in every part of the Empire.

If there were to be separate military and civil services and the former was to be local Indian service, as opposed to an Imperial service it would be difficult to induce Europeans to join either service unless they were offered specially high pay. He did not think the civil service would be sufficiently attractive to the class of graduates who formerly went into the Indian Medical Service chiefly with a view to civil work, as their position in an Indian service that was not military would be too doubtful. He did not think, however, that such a service would be satisfactory. He would rather have officers in civil employ pass through the military service and be liable to recall to military duty for the reason that a better class of men would enter the service.

(General Hchir.) He thought that the question of the conditions of service in the Indian Medical Service being brought into line with the Royal Army Medical Corps was one for a committee of experts. He certainly thought that men should be examined before promotion, but whether they should go over the heads of other men was a matter that should be worked out. All he wanted was to bring the two services into line in respect of terms for officers serving side by side in India. The difficulty he saw in a Promotion Board to determine the merits of officers in India was that you would have many boards, because there could not be one examination for all the men at the same time; and it would be hard to co-ordinate the examinations and promote the men fairly.

He would favour the system of promoting officers to the rank of lieutenant-colonel by selection and not by the time limit of 20 years. He would do away with the "selected list" of lieutenant-colonels, but the pecuniary interests of officers already in the service should be safeguarded.

He agreed with the suggestion that the period that an officer of the Indian Medical Service spent in civil, if he is allowed to come back to military to serve periodically, may be an important asset to the army in India by improving the standard of treatment in military hospitals.

He did not think it would be worth while to induce independent practitioners to form part of the war reserve. They could be offered terms when war broke out as had been done during the late war, but he was in favour of giving them a subsidy.

From the civil point of view the earlier an Indian Medical Service officer went into civil the better. He would say that the best time was after completing two to five years' service. If the period during which an officer might remain in civil employ were limited to five years, a larger number of officers would be able to get into civil.

He thought that a combination of the Royal Army Medical Corps and Indian Medical Service to form a unified Corps in India would form a really efficient military medical service.

In reply to a question as to the number of appointments which are considered in the civil to be more or

17 February 1919.]

The Hon'ble Major-General W. R. EDWARDS.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

less indispensable, and from which officers ought not to be brought back in the case of war, the witness stated that 160 men were kept permanently in civil for the needs of Government out of a total of 780.

(General Hendley.) With regard to the suggestion that there was going to be a big boom in the medical services, the witness denied any such possibility. If there was a large increase in the medical services, he thought the public health services would be increased and more dispensaries would be opened. The only expansion in the higher appointments that he could see was in the direction of preventive medicine and public health. At present they supplied those appointments from three sources: the war reserve of the military side employed as the Imperial Civil Medical Service, that is, from the present Indian Medical Service; the second was the Provincial service recruited and controlled provincially; the third consisted of medical men individually engaged but not belonging to either the Imperial or provincial services. These men may be either European or Indian. Any large increase in the civil medical service would be principally Indian. With regard to getting reserve from among these men, the provinces might well make a rule than all men engaged for provincial service would be liable to military service.

Very few of those who had taken temporary commissions in the Indian Medical Service during the war, both civil assistant surgeons and private practitioners, were men of experience and standing. Such men were unwilling to give up their civil appointments which carried private practice. Most of the volunteers were junior men who had little to lose.

His opinion of officers of the Indian Medical Service who had been recalled from civil to military duty during the war was that they had done good work, but were inferior to Royal Army Medical Corps officers as military medical administrators. He had heard occasionally of exceptionally good men, but many had not proved very successful. The Indian officers, who had taken the place of Europeans in civil employ, had not been altogether satisfactory. There had been many complaints.

He had felt it very strongly not having the station hospital system to see what the Indian Medical Service officers could do when placed in the same position as the Royal Army Medical Corps officers.

He greatly regretted that the Indian station hospital system had not been introduced many years ago. Under the regimental system Indian Medical Service officers in military employment had received very little useful military training; so that their want of success on recall from civil to military duty in later years was not surprising.

(Mr. Hignell.) He dated the present discontent in the Indian Medical Service to the time of Mr. Morley about 12 years ago.

One of the primary aims he set before himself as Director General was to maintain and promote the prestige and interests of the service to which he belonged, and in considering the problems before this Committee he had this laudable ambition always present in his mind. He admitted that a natural amount of bias would exist in the minds of Indian Medical Service officers, but he was certainly of opinion that this new service could not be established without combining the whole of the Medical Department into one corps.

He anticipated a very large expansion of the civil medical needs of India, which, in the past, had not been adequately looked after.

He admitted that during the recent war the best medical men in the provinces were taken away to meet military requirements but emphasised that the civil medical needs of the country would always have to be subordinated to military requirements during a war of great magnitude. He contemplated that there should be only one head of all the medical services, civil and military. That head would be under the Member or Minister in charge, preferably a

Member for Public Health or possibly Education Member. The Military service would be under the Commander-in-Chief. In case of a difference between the civil member of Council and the Commander-in-Chief the Council would settle the dispute.

With regard to the return of medical officers, from the army to civil employ, for which the Director General, Indian Medical Service, had asked for some months past and which the Director, Medical Service in India had been unable to carry out he thought that, until peace was established, he could not expect the officers to be returned.

(General Giffard.) He thought that the dual control (civil and military) of one unified medical service would lead to less friction than that arising from a similar duality of control with two services, as at present.

The formation of an auxiliary corps, as suggested in scheme A would lead to greater friction than at present.

With reference to the suggestion that the Royal Army Medical Corps and the Indian Medical Service should continue to exist as at present, and a separate Imperial civil service be created, he felt certain that under such circumstances the Imperial civil medical service would cease to exist.

It was doubtful if Europeans would join a separate provincial civil medical service unconnected with the Indian Medical Service unless very high rates of pay were offered.

If the Indian Medical Service managed the military and the military reserve in civil, as at present, and then allowed a large provincial civil service to grow up, that provincial service would be almost entirely Indian. If, however, the Government was strong enough to insist that a certain number of appointments which affected the European officers of the various civil services, should be held by Europeans, in the proportion of two Europeans to one Indian, that would solve the difficulty.

If there were no Indian Medical Service officers in civil employ the army would have to rely for their reserve on Indians, because Englishmen would not come out to India for the provincial services.

With regard to the suggestion that it might be necessary to bring pressure to bear on local governments to allow their provincial services to be depleted in time of war, he could not imagine any condition in which the civil needs of a country during war would be left undisturbed. The country would be lost. Somebody had to go, whether it was a service officer in civil employ or an Indian in civil employ. It made no difference.

He did not think that a system of short time contracts could be advantageously adopted in India, owing to difficulties connected with the language and customs of the people.

If it were found impossible to unify the medical services in India, the only alternative was to improve the Indian Medical Service as a military service under the station hospital system. The rates of pay and conditions of service generally should be made as good as possible, but it would still be necessary in order to render the service attractive to have a considerable cadre in civil employ.

With reference to the opinion of the Adjutant-General that if a military medical officer went to the civil he would not be as useful to the army as if he stayed permanently and continuously in military employ, the witness stated that they had not tried it with the station hospital system; the men had been recalled with no military training.

(President.) The unified medical service which he contemplated would be primarily constituted on the basis of military needs; that is to say it would provide for the army both in peace and war. This would necessitate its having a large reserve which must in peace time be employed on civil duties. This war reserve would be distributed among the

17 February 1919.]

The Hon'ble Major-General W. R. EDWARDS.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

provinces, and round it, as a nucleus, the provinces would build up their own medical services. He did not think that the cadre of the unified service would have to be much larger than the present cadre of the Royal Army Medical Corps and Indian Medical Ser-

vice combined, provided that officers before going to civil employ had received a good military education.

The war reserve required in the future would not, as far as he could see, be much greater than that which had been maintained in the past.

18 February 1919.]

Mr. H. B. HOLMES.

*(The schemes and questions referred to by witnesses are contained in Volume III.)***At Delhi, Tuesday, 18th February 1919.**

PRESENT :

S. R. HIGNELL, ESQ., C.S.I., I.C.S. (*Presiding*).

MAJOR-GENERAL G. CREE, C.B., C.M.G., A.M.S.

MAJOR-GENERAL P. HEHIR, C.B., C.M.G., C.I.E.,
I.M.S.

MAJOR-GENERAL H. HENDLEY, K.H.S., I.M.S.

THE HON'BLE MAJOR-GENERAL G. G. GIFFARD,
C.S.I., I.M.S.LIEUTENANT-COLONEL A. SHAIRP, C.M.G., Indian
Army.

LIEUTENANT-COLONEL G. B. A. RIND, Indian Army.

MAJOR A. A. MCNEIGHT, I.M.S. (*Secretary*).

MR. H. B. HOLMES, Controller of Traffic, Railway Board, Government of India, called and examined.

(*President.*) The witness represented the Railway Board. He had simply been asked to give evidence before the committee, but had not been furnished with the views of the Board. He had glanced through the schemes but had not studied them thoroughly.

There were both State and Company railways. The medical arrangements on the State railways varied. On the E. B. Railway there was a Chief Medical Officer in administrative charge of the Medical Department, but in a large place like Calcutta, the headquarters of the railway, they had generally one of the senior Government medical officers, who acted as a consulting physician to the railway, and attended to the railway officers and their families. He also advised the Agent generally as to the medical arrangements.

The Company-owned railways engaged their own doctors.

A different system was in force on the O. and R. Railway, of which the Civil Surgeon of Lucknow was the Principal Medical Officer. This was a very unsatisfactory arrangement as it was impossible for the Civil Surgeon to devote sufficient time to the needs of the railway in addition to his other duties.

Each railway should have a medical officer of its own as its administrative adviser at its headquarters. At present difficulty was experienced in getting doctors. For instance if a special officer was required for the O. and R. Railway Government had to be approached to detail a man in the service of Government for the line.

The Civil Surgeon, Lucknow, was their Principal Medical Officer and under him there were subordinate officers. At the bigger stations such as Moradabad, Fyzabad and Benares the Civil Surgeon was given an honorarium for attending officers and their families. This was also unsatisfactory. What was really wanted

was a man for the railway who could go round and inspect the places, as there was a good deal of work in connection with sanitation, the inspection of refreshment rooms, etc., and it was impossible for a civil surgeon to cope with it.

The remuneration paid by the railway was the same as paid by Government. It would improve matters if the rates of remuneration were increased by the railways, as was contemplated by Government.

Practically no Indians were employed in the superior medical staff of the railways. On the E. B. Railway, however, the Principal Medical Officer was an Indian and had held the post for many years.

(*General Hendley.*) The civil surgeons were on the whole contented with the treatment they received from the railways in the matter of their allowances, etc. The Civil Surgeon at Lucknow received Rs. 200 a month and had recently asked for an increase on the ground that the allowance had been fixed many years ago, but that was the only representation on the question of increasing emoluments of which he knew.

He could not say that the railway employes had complained about the medical arrangements during the war.

(*General Giffard.*) The ideal system would be for the railways to have men of their own. He would much prefer to have Government medical officers rather than that the railway should look out for doctors itself, as he was of opinion that the Government officers were better than the men otherwise available. No doubt a Government medical officer could not inspect the railway work thoroughly in addition to his duties, but if such a man were specifically detailed for this work it would be of great advantage. The Company lines would also prefer this system. The State and the Company lines would, he thought, not be deterred by the fear that under such a system a considerable number of men might be taken away from them in time of war.

MAJOR W. R. DURHAM, I.M.D., in sub-medical charge, British Station Hospital, Ambala.

Written statement.

1. It will probably have an adverse effect on recruitment unless the prospects of all grades throughout the service are improved financially.

2. To the extent of about 50 per cent. amongst those with less than 15 years service.

The specific facilities suggested are as follows:—

(a) The present two years' course for members of the service in the United Kingdom to be reduced to one year.

(b) The preliminary educational test required by the General Medical Council be waived in the

of assistant surgeons already in the service of the Government.

(c) Certificates of attendances in medical colleges in India be granted free of charge.

3. I would be prepared to serve in Indian station hospitals as a warrant officer under the condition that as a warrant officer I belong to a unified medical service—not otherwise.

4. Honorary commissions as such are regarded as valueless hence should be substituted by substantive rank made applicable to senior grades amongst military

18 February 1919.]

Major W. R. DURHAM.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

assistant surgeons, who have no registrable qualification and not given only to those who have.

5. Yes. (a) Six months after three years' service. In United Kingdom (b) three months in any one special subject; (c) one year.

6. A beneficial effect in that it will attract a better type of recruit and stimulate professional efficiency.

7. It will render the position difficult and have a bad effect on discipline, unless Royal Army Medical Corps rank and file during term of employment in India belong to the unified medical service.

8. (1) No, as the pension rates are the same now as those existing 50 years ago, and in the case of senior men, do not secure even half pay on completion of thirty years' service or more.

(2) The marked depreciation of the purchasing power of the rupee.

9. No. The provision is insufficient owing to the small scale of pay, high cost of living and education of

children; it is an absolute impossibility to provide for a widow.

10. Yes. Recruiting, training, status, housing.

11. Yes. Professional executive duties should be allotted to military assistant surgeons in military hospitals.

12. Does not at the present time attract the best of the class of young men which it would do with better pay and prospects.

13. Formation of "Selection Boards" at all large military centres (previous to competitive examination) with power to accept or reject a candidate.

The raising of the age limit 18 to 20 years: and also to open recruiting to men in the regular army who come within the age limit and are in possession of first class army certificates of education.

14. The course should be the same as the M. B. B.Ch.

15. No.

MAJOR W. R. DURHAM, called and examined.

He had entered the service in 1885, and had been on military duty ever since. He had seen active service in China (1900), France (1914-15), and with the Marri Punitive Force in 1918. His present pay was Rs. 450 per mensem.

(General Cree.) If the rank and file of the Royal Army Medical Corps were employed in British station hospitals in India, or another similar local corps organized, the position of assistant surgeons would not be affected. Assistant surgeons would still start their service as warrant officers, and he did not think that friction would arise. In France he had been in a hospital where assistant surgeons worked side by side with men of the Royal Army Medical Corps, and there had been no friction, except at one time when he was acting as Quarter Master. In a hospital in India where the Royal Army Medical Corps were employed, the duties of the assistant surgeons should be professional while the sergeant-major would be responsible for discipline.

The auxiliary corps suggested in scheme A would be an inferior service and looked down on, unless it were to be treated as part and parcel of the Royal Army Medical Corps, in which case there would be no difficulties.

(General Hehir.) The position of assistant surgeons while undergoing training was that of a military pupil in a civil college. They received practically no military training during their course, except a certain amount of drill under a volunteer sergeant. A senior officer of the Indian Medical Department was in charge of the pupils and responsible for their discipline.

The best type of Anglo-Indians do not at present enter the Indian Medical Department. They join, in preference, the Survey, Public Works, or Telegraph

Department, where the pay and prospects are better. Those who enter the Indian Medical Department are chiefly boys whose parents are unable to pay for a good general education. Therefore, if the standard of education required of candidates was to be raised, recruiting would suffer, unless the conditions of service were very greatly improved. If this were done the better class men who now go to the Survey and other departments would be attracted. The present age for entrance (16) was too low and should be raised to at least 18.

(General Hendley.) Many assistant surgeons would go to England to pursue their studies if they could afford it. The grant of scholarships would enable them to do this. These scholarships might be granted at any time after the third year of service.

The only real attraction which the Indian Medical Department holds forward is the prospect of civil employment and this falls to the lot of only a small proportion of its members.

(General Giffard.) He would have entered civil employment himself had he been given the opportunity. The real cause of the assistant surgeon's desire to transfer to civil employ was his desire to get away from his anomalous and unsatisfactory position in the army.

If the conditions of service were improved and better class candidates induced to enter the department, they would be content with warrant rank to start with, provided there was a prospect of promotion to commissioned rank.

(Mr. Hignell.) The want of a registrable qualification was a very real handicap. He had himself felt it as such most keenly, when he was serving in a war hospital at Brighton.

2ND-CLASS ASSISTANT SURGEON G. W. DOYLE, Indian Medical Department, Officers' Hospital, Abbottabad, called and examined.

He joined the Indian Subordinate Medical Department (now the Indian Medical Department) in February 1905 from the Calcutta Medical College. His present pay was Rs. 200 per mensem.

He had been on military duty all his service. He had spent three years on active service in France and Mesopotamia.

He was not contented with his present position or prospects. The chief causes of his discontent were (1) the almost impossibility of his being promoted to the senior grade of assistant surgeons, (2) the inadequacy of his pay, and (3) the want of proper position and social status due chiefly to the fact that the Indian Medical Department belonged to neither the Royal Army Medical Corps nor the Indian Medical Service, and was a department without a head of his own.

At times the fact is that an assistant surgeon did not possess a registrable qualification. He quoted an in-

stance when he was acting as medical officer in charge of a regiment, and a professional opinion which he gave was not accepted until it had been corroborated by a commissioned medical officer. This medical officer happened to be a European, but he might have been an Indian civil assistant surgeon holding a temporary commission in the Indian Medical Service.

(Mr. Hignell.) He had studied the schemes and considered that scheme A would present great difficulties if assistant surgeons were absorbed into the Royal Army Medical Corps as warrant officers; but not if they were only affiliated to the Royal Army Medical Corps, and employed on purely professional duties.

(General Cree.) If the members of the auxiliary corps proposed in scheme A possessed European qualifications, he did not anticipate any difficulty in this part of the scheme, except perhaps between officers of the corps and those of the Royal Army Medical Corps.

18 February 1919.]

2nd-class Assistant Surgeon G. W. DOYLE.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

This possible difficulty would disappear if officers of the auxiliary corps went through a course at the Royal Army Medical College. It would also be necessary to prevent officers of the auxiliary corps becoming subordinate and inferior to the rest of the Royal Army Medical Corps, and to ensure that they would have the same privileges of pay, rank and promotion as other members of the Royal Army Medical Corps, but would be confined to service in this country. They should also have the same opportunity as the Royal Army Medical Corps of holding higher administrative grades, and should be borne on the general roll of the Royal Army Medical Corps serving in India. There might easily be friction between Anglo-Indian and Indian in the auxiliary corps unless both were given the same educational facilities. It would not be possible to find many Anglo-Indians who would be prepared to pay largely for their own educational training if the prospects of the service remained as at present even though Government promised to find employment for them in the medical department. The fact that Anglo-Indian members of the auxiliary corps were educated at Government expense, while the Indian had had to pay for their training would not lead to any difficulty in the Corps, but would probably lead to a certain amount of political agitation. If, however, the same opportunities were given to Indians as to Anglo-Indians there would be no cause of friction.

With regard to the question as to whether difficulties would arise between members of the Indian Medical Department and warrant and non-commissioned officers and men of the Royal Army Medical Corps, if the latter were employed in British station hospitals in India, he considered that if the duties of assistant surgeons remained as at present, there would be friction between them and the Royal Army Medical Corps sergeant majors, as both would to some extent be employed on the same duties. If, however, the assistant surgeon was in charge of Royal Army Medical Corps orderlies while in the wards, and the sergeant major in charge of them outside the hospital, friction would not arise.

(General Hehir.) Asked when an assistant surgeon, who desired to do so, could afford to go to England to obtain a registrable qualification, he stated that that depended on when he was transferred to the civil side, but if he had no chance of getting into civil employment he could never hope to get to England.

If he had a registrable qualification which entitled him to practise in this country and had joined the station hospital as a qualified warrant officer he would not remain there under the present conditions. The existing conditions compelled them to remain there for a certain length of time and they were practically bound there and it was impossible for them to move owing to the want of a proper diploma.

His duties normally were those of a head clerk, compounder, ward master, steward and store-keeper; at times he was also called on to perform the duties of a surgeon and physician, though the latter was a minor part of his work, and was only required on certain occasions and in emergencies.

He would gladly subscribe to a provident fund, but no assistant surgeon could afford to do so.

(General Hendley.) He anticipated there would be some difficulty with regard to the position of assistant surgeons, if all military sub-assistant surgeons were given commissioned rank, owing to the fact that the British warrant officer had no position in the Indian Army. He had found no difficulty at all in his relations with senior sub-assistant surgeons who ranked as subedars. He did not mean to suggest that there would be friction among the officers themselves. The Indian commissioned officers were invariably courteous to assistant surgeons, and, as far as he knew, there had been no friction; but if all sub-assistant surgeons were given commissioned rank it would very likely give them exaggerated notions about themselves which might result in difficulties, which do not exist at present.

He had entered the Indian Medical Department with a view to going to England in time and joining the Indian Medical Service, but owing to financial difficulties he was unable to do so. The primary attraction of joining the Indian Medical Service having disappeared, the prospect of going to the civil side was the only attraction left. This prospect of going to civil employment did form a considerable attraction to candidates. Recruitment would be very adversely affected if that attraction were taken away.

He had not much professional work. If the assistant surgeon class were abolished it would be necessary to increase the number of medical officers, as various positions which were filled by assistant surgeons could not be filled by non-professional men, for instance, assistant surgeons held medical charge of batteries on field service, and were often the only medical men accompanying troops on the march, sometimes for long periods. On such occasions, but for the assistant surgeons, medical officers would have to be appointed.

(General Giffard.) At present Government took school boys at the age of 16 without enforcing any particular standard of education, but if such men were to have registrable qualifications Government would have to take boys at a later age from the school and with a higher standard of education. If the prospects were made sufficiently attractive it would be possible for Government to find candidates who would have had sufficient education to enable them to start their studies with the prospect of obtaining a registrable qualification. The fact that in spite of the drawbacks and the disadvantages attendant on the assistant surgeons candidates were forthcoming was due to the poverty, both social and pecuniary of the candidates. A number of the candidates came from the orphanages.

If the witness were given a free hand he would raise the standard of preliminary education up to the standard required by the university for which the parents will have to pay which he thought the latter would be prepared to do. Then he would give them free medical education at Government expense if the prospects were made sufficiently attractive. He admitted there was difficulty due to the fact that he proposed to give free medical education to the Anglo-Indians while the Indian students had to pay for it, but this had been suggested as the Anglo-Indian community had not sufficient money to give education for a long period.

19 February 1919.]

Lieutenant-Colonel F. A. SMITH.

(The schemes and questions referred to by witnesses are contained in Volume III.)***At Delhi, Wednesday, 19th February 1919.**

PRESENT:

S. R. HIGNELL, ESQ., C.I.E., I.C.S. (*Presiding*).

MAJOR-GENERAL G. CREE, C.B., C.M.G., A.M.S.

MAJOR-GENERAL P. HEHIR, C.B., C.M.G., C.I.E., I.M.S.

MAJOR-GENERAL H. HENDLEY, K.H.S., I.M.S.

THE HON'BLE MAJOR-GENERAL G. G. GIFFARD, C.S.I., I.M.S.

LIEUTENANT-COLONEL A. SHAIRP, C.M.G., Indian Army.

LIEUTENANT-COLONEL G. B. A. RIND, Indian Army.

MAJOR A. A. McNEIGHT, I.M.S. (*Secretary*).

LIEUTENANT-COLONEL F. A. SMITH, I.M.S., Chief Medical Officer, Central India.

Written Statement.

There are at present three medical services under the Indian Government, (a) the Royal Army Medical Corps for British troops, (b) the Indian Medical Service (Military) for Indian troops, (c) the Indian Medical Service (Civil) for civil duties.

The two former are under the orders of the Commander-in-Chief and the last of the Imperial Government or of local governments.

I. *Military*.—The medical supervision for the whole army in India should be in the hands of one medical organisation, for the following reasons:—

- (1) It will tend to economy, as the sick of all corps in each military station will be treated in one group of hospitals, the wards will be separate, but operation rooms, laboratories, dispensing rooms, dressing rooms, etc., will do for all troops, saving the present duplication which of necessity is more costly: similarly there will be a saving in the executive and subordinate personnel.
- (2) It will tend to efficiency, as for the same outlay operation rooms, etc., can be better equipped: and again because with larger institutions, the staff will be larger in each and by means of consultation between them, diagnosis of disease and the treatment of patients is bound to improve.

II. The service to carry out these duties should either be the medical department of the British Army or a local medical service for India: the latter might be called the Indian Medical Corps. In my opinion the latter arrangement should be adopted for the following reasons:—

- (1) A local corps possesses special knowledge of all diseases occurring in India (and this special knowledge is of the utmost value to the patients); doctors coming to India for occasional tours of service can undoubtedly gain this knowledge, but clearly not to the same extent as those continuously serving in India.
- (2) The local corps already exists in the Indian Medical Service with a high prestige—though perhaps not as high in recent years as it formerly was—and with a long record of valuable work in tropical medicine and general surgery.
- (3) Through this Corps the medical requirements of the civil population can be met, *vide infra*.
- (4) It is possible thus to provide and to maintain in a state of efficiency a reserve for times of emergency, *vide infra*.

My objections to placing the whole of the army in India under the Royal Army Medical Corps are as follows:—

- (1) Temporary service in India leads to less knowledge of conditions and disease than does permanent service.
- (2) The Royal Army Medical Corps cannot provide for the needs of the civil population.
- (3) This arrangement would produce no war reserve, which would have to be found through other organisations.

I would therefore recommend one Indian Medical Corps to provide for the medical requirements of the whole army serving in India. From this corps officers would be provided as detailed below for civil appointments.

III. *Organisation*.—Combined station hospitals for British and Indian troops and followers with separate wards for each category, and one officer commanding the whole.

Where lines are far apart, transport by motor ambulances would be arranged.

Personnel—

- (i) Officers of the Indian Medical Corps.
- (ii) Assistant Surgeons.
- (iii) Sub-Assistant Surgeons.
- (iv) Nurses.
- (v) Apothecaries.
- (vi) Clerks.
- (vii) Hospital Corps.
- (viii) Menials.

Recruitment.—The Corps would not be open to Indians as long as Indians are not ordinarily granted combatant commissions in the Indian Army; as soon as these are granted Indians would be admitted to the Corps. There will be ample scope for Indians in the civil medical service, *vide infra*, and their exclusion from the military service would be no hardship as with very few exceptions those who have hitherto been commissioned in the Indian Medical Service have entered the service with the view of getting into civil, and many who have remained in military, owing to there being no civil openings for them, have been disappointed in having to do so.

Admission will be as for the Royal Army Medical Corps and Indian Medical Service by examinations held in London: and I think it would be an advantage to allot a certain number of nominations to the principal medical schools.

Formation of service.—Taking the army on its pre-war basis I gather the number of officers required will

19 February 1919.]

Lieutenant-Colonel F. A. SMITH.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

be 770*: 269 Indian Medical Service officers were doing military duty before the war. The 500 required would be obtained by Royal Army Medical Corps officers transferring into the new corps, and by special recruitment. Under the present conditions I admit the full number would not be obtained from these sources; but if any British medical service is to be maintained in India the conditions of service must—as I think it is admitted on all hands—be vastly improved.

The Indian Government either in the military or civil does not require a cheap medical service so much as an efficient one, and that will be much more costly now than it has been in the past.†

Organisation.—The whole corps to be under the Director, Medical Services in India who should have from six to ten officers serving on his staff in charge of the several departments; a portion of these would form the military medical board for deliberation on knotty points, recommending promotion and postings.

The principal medical officer in each division, and the larger brigades, would be the Assistant Director, Medical Services, with his staff at headquarters as at present; and under him would be the officers commanding hospitals. Specialists should be attached to headquarter station hospitals. Their posting would be arranged by the military medical board. Specialists should receive extra remuneration say of £50 per annum and should be appointed permanently from men possessing special qualifications, thus the F. R. C. S. (England) for surgery, the M. R. C. P. (London) or the M. D. (London) for medicine, the Rotunda diploma for midwifery, the D. P. H. for sanitation and the B.Sc., or similar degree for chemists, etc.

Consultants should also be arranged for: for organisation officers might be temporarily appointed for a few years from the Royal Army Medical Corps; and for medical and surgical cases arrangements should be made for calling in the men at the top of their profession in the larger Indian towns.

Assistant surgeons would serve as at present for British troops and sub-assistant surgeons for Indian troops.

Other grades of the present medical organisation would remain as at present, with the addition of the services of nurses for Indian troops, and the appointment of clerks to do the clerical work which at present absorb so much of the time of assistant surgeons.

Pay and allowances.—I understand the Government of India are considering the question of the revision of the pay for the Indian Medical Service.‡ This revision is very necessary, as unless a very substantial increase is granted the Corps would not prove attractive to the right kind of medical men. The heads of the British medical schools know the pulse of the profession regarding remuneration, and I consider they should be consulted either directly or through the British Medical Association as to the pay of the Indian Medical Corps. The schools have to provide recruits; if they are not satisfied with the prospects out here men will not join the service.

As I have mentioned above I consider specialists' pay should be granted to the required numbers of specialists in each subject permanently on a fixed scale and only to men who possess special qualifications.

Officers commanding hospitals should receive charge allowances based on the present scale. I would restrict allowances to these two categories and staff allowances for officers serving on the staff of the Director, Medical Services and Assistant Director, Medical Services. I consider the allowances should invariably be drawn on privilege leave.

As Indians will be in the civil medical service, and probably eventually be commissioned in the military, I think a definite proportion of the pay should be entered as foreign service allowance, as it is obviously going to cost the Britisher much more to live out here and

keep his family part of the time at Home, than the Indian who is living in his own country. This should commence say at Rs. 300 a month with an increment of Rs. 50 every 5 years.

Military pay and allowances.—As a larger proportion of men will be in military, there will be a smaller proportion in civil. Hitherto prospects of civil have attracted men to the Indian Medical Service and injudicious interference in the past with the emoluments of civil practice has been a large factor in producing the crisis in the service. Inducements to enter must be therefore correspondingly increased in the future.

Leave.—Privilege leave as at present, and every officer should be encouraged to take it either to enjoy rest, or to get a change of scene and surroundings by attending one of the large civil hospitals during his leave. Facilities for their doing so should be arranged. After every 4 years' service, one year's furlough to be compulsory—to commence from a fixed day twice a year, when men will hand over and those returning from leave take over. I would have no exception to this rule, because the service is bound to suffer if men remain out here year after year, without a rest, as many do under present conditions; a portion of the furlough will be spent in study at Home to prepare for promotion examinations and to qualify for specialists' appointments.

Corps medical college.—To be associated with one of the larger station hospitals and if possible in a place where there is a large civil hospital, and certainly where residence for troops is possible all the year round, e.g., Poona or Mhow. The alternative is to have it based on a sanatorium somewhere in the hills, open summer and winter. One site for the summer and another for the winter. I do not recommend, as it would enormously increase the cost and interfere with the continuity of work.

1. Objects of college:—

- (i) To give all officers on joining a 4 months' course of training in tropical diseases, and military routine.
- (ii) For courses of instruction for promotion examinations.
- (iii) For instruction of civil medical officers who will form reserve.
- (iv) For research work.

2. **Teaching staff.**—To be appointed for 4 years by the Director, Medical Services and Military Medical Board, from whatever source the best men in each subject are available. The hospital (or sanatorium) staff will consist of the lecturers and demonstrators, supplemented as necessary by Indian Medical Corps officers. The commandant will be a senior Indian Medical Corps officer.

Promotion.—On a similar time-scale, as at present in force, with corresponding acceleration in promotion to major as has been granted to Indian Army officers since the present time-scale has been fixed for the medical service.

Promotion to major and lieutenant-colonel after passing the prescribed examination.

Examination to be held twice a year at the Medical Staff College.

Officers to be detailed for a course of instruction at the Medical Staff College before their examination is due; this to count as duty.

Brevet rank.—Brevet rank in the Indian Medical Service should as at present carry seniority in the army, but not in the Corps. It should, however, also carry with it the pay of the rank.

Military reserve.—The reserve will be organized as follows:—

A. Officers.

1. The leave cadre, some 30 per cent. of the strength.
2. Corps officers in civil employ.

* Of this, however, I have no definite knowledge, but I should be inclined to conclude that combined station hospitals would permit of a decrease in the figure given.

† When the terms of service are improved Royal Army Medical Corps officers might be seconded for service in the Indian Medical Corps for periods of 4 years: such officers would receive Indian pay, but not be eligible for transfer to civil unless they are permanently transferred to the Indian Medical Corps.

‡ So I make no detailed suggestions concerning this except as below.

19 February 1919.]

Lieutenant-Colonel F. A. SMITH.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

3. The civil medical officers.*

4. Private practitioners possessing the necessary qualifications (a) in India and (b) from Home.

B. Assistant surgeons.

1. Government civil employés.*
2. Private practitioners.

Civil sub-assistant surgeons.

1. Government civil employés.*
2. Private practitioners.

Civil.—This requires expansion and will cost Government more in the future than it has done in the past, but India can afford an efficient State medical service, and money expended on this purpose is a sound financial investment. Government are fully alive to their responsibilities in preventing loss of life by murder and the sapping of the people's energies by slow poison, but are comparatively luke-warm towards loss of life by other preventable causes, and to the debilitating effects of disease—a dead man pays no taxes and a weakling produces little. Health is more important than education, and a healthy illiterate is a greater asset to the community than a man with ill-health who can read and write.†

Military medical organisation is a comparatively simple matter, but the safeguarding from disease of between 3 and 4 hundred million of the general community is a much more intricate problem. The organisation as it exists is an efficient one, and provides an excellent basis for extension.

The present method of drawing the whole of the civilian medical service from the military should I think cease; the proposed restriction of the military tenure to Europeans necessitates this; also a wider field of recruitment will produce a more efficient service.

Recruitment.

1. *Officers.*—Officers from the Indian Medical Corps say 38 per cent. of the civil requirements. Such men to undertake a course at the Medical Staff College once every 5 years up to 20 years' service, and to be appointed to civil after a year's residence in the country, the first six months of which will be spent at the college and the next six months at a station hospital.

B. Indians with a registrable qualification, to be admitted by examination in England, to be recruited as medical students and educated in England for 2 years at Government expense with suitable guarantees of their continuing in service—say 38 per cent. strength. To be liable for military service in war and to undergo periodic training at the College.

C. Europeans 19 per cent. either nominated by the medical schools or admitted by examination in England as above.

D. Assistant surgeons promoted for exceptional qualifications, say 5 per cent. of strength.

2. Assistant surgeons.
3. Sub-assistant surgeons } as at present.

Constitution.—The head of the service should be a member of council. I suggest this increase of status for reasons given above. The medical member should have, working under him, a Medical Board, of ten to twelve officers appointed by selection and not by seniority. The members of the Board will be in immediate charge of the various departments, namely:—

1. Appointments and postings.
2. Sanitation.
3. Jails.
4. Vital statistics.
5. Stores equipment (manufacture).
6. Chemical examinations.
7. Research.
8. Preventable medicine.
9. Medical education.
10. Epidemiology.
11. Hospital buildings and fittings, etc.

The functions of the Board as a whole will be to advise Government as to legislation, preventive medicine,

medical education and registration, and will decide, subject to Government control, the general policy of medical relief in India.

Amongst the functions of the Board and the various departments will be—

- (i) The collection of vital statistics.
- (ii) The preparation of standard plans for all hospital buildings, grain stores, etc., and scales of standard equipment and stores.
- (iii) The issue of literature on medical subjects for use in primary and secondary schools.
- (iv) The issue of pamphlets in various Indian languages directing the people what to do during epidemics.
- (v) The supervision of all medical education in India, and the granting of degrees and diplomas, and the appointment of lecturers.
- (vi) Allotment of men for the civil medical requirements of the various local governments.

The immediate needs of the country are too vast to remain in the control of one officer, however, able he may be, and the formation of a Medical Board as suggested will enable the head of the department to thoroughly thresh out each subject that comes up to him for decision, and to give rulings and decisions that will be weighty and unassailable.

Each local government will have its chief medical officer as at present, who will be responsible for posting the men allotted to his province for civil medical duties and to jails, for compiling vital statistics, and for the inspection of all medical institutions within his area. His will be a purely administrative appointment and he will be debarred from private practice. All appointments will be made, as described, by the Medical Board or by the provincial civil medical department, and none will be made by any other agency or influence as far as possible. Thus it should be possible to get each man into the appointment where he will be most useful, and his abilities can be employed to the best advantage.

Pay and allowances.—The scale of pay for officers will be the same as in the Indian Medical Corps depending on length of service, except that Indian members will not draw the expatriation allowance. Civil appointments vary in importance and carry varying allowances ranging from Rs. 50 to Rs. 1,000 a month, according to the additional duties attached to the appointment on behalf of Government or local bodies. I think these separate allowances should cease and that all civil appointments should be graded and carry civil allowances varying from Rs. 100 to Rs. 500 per mensem. Where the administrative duties are heavy some should be handed over to assistant surgeons under the supervision of the civil surgeon. All present local charge allowances might either be pooled, and paid to Government, or relinquished. Allowances to be drawn during privilege leave, and to count towards furlough pay.

All members of the civil medical service be allowed private practice as under present conditions, but the general rules of medical etiquette to be applied, the surgeon in one district not to attend patients in others, unless with the local officer.

The specialists' allowance will not be paid to Indian Medical Corps officers who are transferred to civil.

War reserve.—All officers, assistant surgeons, sub-assistant surgeons to be liable for ordinary military service during war time except those with more than 20 years service, who will only be employed as consultants when required.

Every 5 years each officer will undergo a course of instruction for one session at the Medical Staff College, that period will count as duty, and will carry civil allowances. Similar courses might be arranged for Assistant Surgeons and Sub-Assistant Surgeons.

Leave.—Privilege leave one month a year under present rules.

One year's furlough to be taken compulsorily after 4 years' residence in the country; for Indian members this to be reduced to six months if they so wish.

* Liability for military service during war time to be one of the terms of their appointment.

† The preservation of manpower for the industrial and agricultural development of India is a serious economic problem.

19 February 1919.]

Lieutenant-Colonel F. A. SMITH.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

Duties to be handed over to relieving officers on a fixed day twice a year and no exception to be permitted.

During the privilege leave all allowances to be drawn, and such to count towards furlough pay.

Assistant Surgeons.—Sub-assistant surgeons to be given one month's leave each year, and six months furlough after 4 years. It should be arranged for them that leave when due can always be obtained.

A. Questions for witnesses.

1. I prefer scheme C with the modification suggested in my note.

2. I think the scheme will meet all requirements. Indian opinion may object to the exclusion of Indians from the military branch; this as proposed is a temporary arrangement and might be deleted; up to 10 or 15 years ago the proportion of Indians who gained admission to the Indian Medical Service was small: it is a question of the prospects offered, if they are good, Europeans will compete; and the proportion previously obtaining between the two races might be again attained. The military medical service must be preponderantly European, and the preponderance must be maintained by safeguards, if necessary.

3. This entirely depends on the remuneration offered and the service prospects in India. I have made no suggestions regarding pay; this should be determined by the Medical Department of the India Office in consultation with the British Medical Association and the heads of the larger medical schools in the United Kingdom. Unless the medical schools are satisfied recruits will not be forthcoming.

4. I gather from Dr. Lankester's Report on tuberculosis that as far as certain jails are concerned the effect has been disastrous: as to civil districts, the effect varies according to the stamp of man put in. Indians appointed to the district under my control have done well, but Europeans have on many occasions called in English doctors from elsewhere.

5. Yes. It would be depleted by war on a large scale. This must of necessity happen in any country under similar conditions: the private practitioner would temporarily replace officers withdrawn from civil. I am leaving the senior men who would take charge of all important posts.

6. Yes.

7. Yes; with a partial military training as suggested. The reserve must be available in India.

8 and 9.

10. I have noted this in my minute. For special training and special research the Medical Board would grant additional leave to count as duty as necessary.

11. Yes. This should be one of the departments working under the Medical Member of Council.

12. It certainly has declined. Indians are coming to the front and other things being equal Indians prefer attendance by doctors of their own race.

B. Questions for Service Officers.

1. Three years in military and about twenty in civil and foreign.

LIEUTENANT-COLONEL F. A. SMITH, I.M.S., called and examined.

(General Cree.) He considered that a unified medical service is necessary including both military and civil. He would recruit for the civil medical service largely through the military. 40 per cent. of the civil medical service should consist of officers who had thus entered it from the military side no matter to what extent the future cadre of the civil service might be increased. If at any time the military service was unable to supply 40 per cent. of the civil he would recruit direct for the latter in England. There would be no difficulty about this under the proposals contained in his written statement as the civil medical service would always prove attractive to Europeans.

He agreed with the suggestion in scheme A that there should be combined hospitals for British and

2. Yes. The service is undermanned; many men have far too much work to get through, and leave is difficult to obtain.

(ii) The right of civil medical officers to private practice should be definitely laid down. We are asked to join the service under the express condition that we 'are not debarred from taking private practice as long as it does not interfere with other duties;' but it has been ruled that we have no statutory right to private practice either in certain prescribed limits, or as a general permission.

(iii) For a period of 15 years commencing from 1892, the period spent on probation was not counted as service towards promotion and pension; it was eventually restored, but not to officers who joined during this period. All officers now serving should be treated alike in this matter.

(iv) Appointments should be made by a board of medical officers as I have suggested.

(v) All allowances should be drawn during privilege leave, and count towards pension. The Secretary of State has recently sanctioned this, but its value to the Indian Medical Service officer is largely annulled by the Government ruling restricting the concession to Imperial allowances, and excluding local allowances, which form a large item in providing the Indian Medical Service with emoluments. This is a point that I think should be taken up at once.

3. Yes. There is frequent friction. I see less of this than most officers as serving under the Foreign and Political Department. I do not frequently come across other medical officers.

4.

5. (a) One year. (b) Twenty years.

C. Special questions.

1. Both factors operate. The general standard of the European practitioner is higher than that of the Indian, in birth, training and experience. A European officer prefers a European doctor, and the preference is usually insisted upon when women and children are concerned. I agree with para. 22 of Scheme B.

2. They have not usually been satisfied; in large numbers of cases European doctors have had to be summoned from neighbouring stations, or the patient transferred.

3. I have not come in contact with them but speaking generally one can say that with diminished competition less competent men have gained admission during recent years to the Indian Medical Service.

D. Medical Store Department.

1. (a) From a Shipping Agent in London at trade prices plus a 2½ per cent. buying commission. (b) From European firms in India.

2. I should be glad to make all purchases through the Medical Store Department.

Indian troops, but he would not combine these with civil hospitals, as the civil population of India would shun hospitals in which British soldiers were patients.

Officers of the new Indian Medical Corps should be trained at the Medical Staff College to be established in India and not at the Royal Army Medical College, Millbank, and Royal Army Medical Corps Depot, Aldershot.

(General Hehir.) The witness stated that the only difference between the existing organisation and the proposed service would be that men would be appointed to the civil after a year's residence in the country, the first six months of which would be spent in college and the next at a station hospital. The officers in civil employ would remain an integral part of the military

19 February 1919.]

Lieutenant-Colonel F. A. SMITH.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

service. But it was immaterial whether they received military promotion.

He favoured the proposal that military promotion should depend on the results of examinations, but would not have accelerated promotion depend on these results alone.

With regard to the elimination of Indians from the military branch of the proposed medical service, this would automatically occur if the former attractions of the Indian Medical Service were revived in the new service. In this event you would only get about 5 per cent. of Indians as not more would succeed in the competitive examinations.

He would second Royal Army Medical Corps officers as a temporary measure to the new service until the Indian Medical Corps expands sufficiently. They should be used for all duties of the Indian Medical Corps and not confined to work with British troops, but should not be transferred to civil employ. Secondment should be for nine years, which should include one period of furlough.

If the European element was limited in the service he was of opinion that less efficient men would be forthcoming.

He would not favour the introduction of female nurses in the Indian Army.

(Colonel Rind.) A man going from the military to the civil should remain in civil permanently, unless required for military duty in case of emergency.

(Colonel Shairp.) In view of the increasing number of Indians who would compete in examinations he thought that it would be advisable to place a limit on the proportion of Indians to be allowed in the service.

(General Hendley.) With regard to the direction in which the civil cadre would be increased and whether it would be under the Imperial or local government, he was inclined to think that the present Imperial civil medical organisation would form a frame-work on

which the whole of the provincial organisation would be built up, and that the increase would be under the local governments. The increase would be first in general and then in sanitary work.

He was in favour of the establishment of a Medical Board which would control medical organisation in the provinces, make appointments to medical schools, and advise as to medical education and registration. The cost would be borne by the provincial governments, as at present. The local governments would recruit locally for the provincial services. There would certainly be an increase in the superior appointments but not to any large extent. There would be a great increase in provincial services in subordinate grade officers.

With regard to the purchase of medical stores he said that both government hospitals and the Native States would be glad to get them from the Government Medical Store Department.

He considered that it was essential to have a war reserve in civil. This reserve would always be liable to recall in case of necessity.

(General Giffard.) Officers of the military side of his proposed service should be sent into civil if they wished to be transferred. Those who elect for civil employ should not come back to military except in case of war.

He thought it very necessary that an Indian, before being allowed to enter the officer grade, either in the civil or military service, should pass the competitive examination in England.

He thought that examinations for a purely civil medical service should be different from that for the Indian Army Medical Corps.

He was of opinion that if recruitment was not carried out through the Royal Army Medical Corps, a better class of men, capable of doing research work and bacteriology, would be obtained.

LIEUTENANT-COLONEL P. B. HAIG, C.B., I.M.S., Chief Medical Officer, Rajputana.

Written statement.

Replies to questions asked of service officers.

I have been in military service 13 years, and in civil service 13 years.

Compared with former times, there is much more work now, of which one cannot complain; but emoluments have fallen off and the expenses of living have greatly increased.

Prior to the war, leave was obtained with difficulty.

During the war, the Indian Medical Service is the only Department of "regulars" in which there has not been a big run of promotion. Indeed promotion has actually been slower for the seniors than in peace time, owing to the retention of officers who would ordinarily have retired.

Personally I have not had friction with the Royal Army Medical Corps, but I have known cases of it.

With two separate corps, such as the Royal Army Medical Corps and Indian Medical Service in India, some jealousy is inevitable.

The obvious remedy is a good scheme for unification.

I would not fix any limit of service for transfer from military to civil.

Transfer from civil to military should be limited to 20 years' service.

Replies to special questions.

In my opinion the demands of European officials for European doctors are mainly based on racial predilection—certainly so far as their families are concerned. It has always been my experience that when a European doctor could be got, his services were asked for.

When no European was available, an Indian was employed, but I have never known of an Indian doctor attending a European lady in a confinement or for any gynaecological complaint.

I have known some Indian medical officers who were thoroughly efficient and capable; as it happened all these were comparatively junior and had been to British medical schools. My impression is that before the war the number of good Indian medical officers was on the increase.

Since the war began I have had considerable experience of temporary commissioned Indian medical officers. The great majority of these had been trained in India and the general standard of efficiency was not high.

Replies to questions for witnesses.

The existence in India of two separate medical services has certain drawbacks and no advantages. Some form of unification is desirable. Of recent years, notably since the Boer War, the Royal Army Medical Corps organisation and efficiency has greatly improved. The same cannot be said of the military side of the Indian Medical Service which has had to struggle against difficulties. The regimental hospital system was obsolete. In many cases regimental hospital buildings were unsuitable, and their equipment insufficient. Promotion to military administrative grades of Indian Medical Service officers, who had spent many years in civil employ and had lost all touch with military methods, was a bad system.

Scheme A appears to me unsuitable for these reasons—

- (a) The proposed auxiliary corps for the Indian army would be an inferior and second rate body, and would not attract men of the quality and capacity requisite for the Indian army.
- (b) It is improbable that Europeans of the necessary stamp would join the proposed civil medical service direct. If this were so,

19 February 1919.]

Lieutenant-Colonel P. B. HAIG.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

and scheme A were adopted then the European element in the civil medical service would consist solely of seconded Royal Army Medical Corps officers. The percentage of these would be insufficient to meet the requirements of the civil authorities for European doctors.

Scheme B appears unlikely to meet the requirements of the civil branch for the same reason as noted under scheme A.

Schemes B and C appear to me to be suitable for both military and civil requirements, if the conditions of service are made sufficiently attractive. If it should turn out, as it is to be hoped, that competition among recruits is keen, then it may be necessary to help Indian candidates with scholarships, as proposed in scheme B, para. 7.

A scheme for a service which would be beyond the power of Indians to enter, in a fair proportion, would not be in accordance with the principles now coming into operation in Indian affairs.

I consider that an Indian Medical Corps on the lines of schemes B and C would, if the conditions of service are good enough to attract men of the necessary standard, meet with the approval of the War Office and also would meet the requirements of the army in India.

In considering schemes B and C two factors are important :—

Firstly, under the altered conditions, which are coming about in India, it cannot be doubted that the adoption of any career in India by Europeans will be a matter for deeper consideration now than it was in the past. Assuming that the medical service, unified on the lines of an Indian Medical Corps, is organised, it may, before many years, be faced with a crisis similar to that which now menaces the existence of the Indian Medical Service.

Secondly, it cannot be denied that in the Indian Medical Service, feelings of discontent and despondency have become widespread, owing to delay on the part of Government in making necessary reforms. Before the war, there had been a marked falling off in the popularity of the service, and this has become much greater during the war. The medical profession in Britain are well aware of these

grievances, and have represented them several times to the authorities.

Unless a marked improvement is made in conditions of service, there is no probability that Europeans of the required standard will join in sufficient numbers to enable an efficient Indian Medical Corps to be formed. India will have to compete with the increased emoluments now easily earned in Britain. Owing to the war having largely emptied the medical schools, the number of newly qualified men will be small for some years, and openings for them in England will be numerous.

I consider that, speaking generally, the result of the withdrawal of European medical officers has been that the few who remain were overworked and where none remained efficiency suffered.

I think that an Indian Medical Corps would meet all civil requirements. Civil requirements would, in the event of war on a large scale, have to yield to military needs.

Schemes B and C would furnish an adequate military reserve. This could be supplemented as proposed in scheme C, para. 31.

I am strongly of opinion that it is essential to have actually present in India, a medical service reserve for war, previously trained in military work.

The Indian Medical Service reserve (civil), was of great value in the war. It provided personnel for all the expeditionary forces, and carried on military medical duties in India.

I recommend recruitment by competitive examination in England, with possibly help from Government, to enable Indians to compete successfully. I also advocate a Medical Staff College in India.

Study "Leave" should count as duty. Government should pay the expenses of courses of instruction.

Paying private practice has greatly fallen off.

Causes.—There are many efficient assistant and sub-assistant surgeons in civil employ, who being less frequently transferred than officers are, have built up practices. In all places of any size, there are now private practitioners. Owing to better communications now existing, patients can go to big centres for consultation, etc. As in Indian houses the conditions are unsuitable for surgery, operations have to be done in hospitals, and the operator does not gain fees. The decline in private practice is not altogether a matter for regret in my opinion.

LIEUTENANT-COLONEL P. B. HAIG, C.B., I.M.S., called and examined.

(*President.*) With reference to the reason of the unsuitability of scheme A, as set out in sub-para. (a) of his statement, supposing the difficulty in regard to the proposed auxiliary corps was surmounted, he did not think the scheme would do much towards the unification of the two medical services. Even were the Royal Army Medical Corps to agree to extend its charter to Indians, and Indians were not required to serve outside India, except with Indian troops, the witness did not think that it would result in the unification he wanted. Such an arrangement would give rise to difficulties, as there would be differentiation of treatment between members of the auxiliary corps and the Royal Army Medical Corps. If you got rid of this auxiliary corps, making Indians full members of the Royal Army Medical Corps, except for their exemption from foreign service, that would not be scheme A, but a different scheme altogether.

If the prospects of the proposed new civil medical service were as good as those now offered to members of the Indian Medical Service, who desire civil employ, he did not think that Europeans of the right stamp could be recruited, as a military service had certain attractions which were not the same as those of the civil, supposing the latter were a purely civil service. The inducements would have to be increased, to compensate for the absence of the military attraction. One of such inducements would have to take the form of bigger pay

The majority of officers joined the old Indian Medical Service as it permitted them to fall back to military service from the civil, were the latter to prove undesirable for any reason. If an officer, for instance, fell into any trouble, or disliked the civil, he would not, under the new scheme, have a line of retreat to the military. It also made provision for less competent officers.

He would suggest a minimum of 20 to 25 per cent. of Indians, as being a fair proportion for admission into the new service.

(*General Hahir.*) He would not put a time limit to an officer who went into civil employ from the military side. An officer should not remain in the civil after 20 years' of service. He would bring him back to the military at intervals of 5 years.

He did not form a favourable opinion of the temporary commissioned officers of the Indian Medical Service, during the late war.

He was in favour of helping Indians by means of scholarships to qualify for the new service at Home, if competition among recruits became keen. He thought that, if the conditions of service were made sufficiently attractive, large numbers would join. There was a great number of Indians who desire to enter the service, if they were put in a position to compete successfully, and this they could not do unless they received financial

19 February 1919.]

Lieutenant-Colonel P. B. HAIG.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

help; so that the percentage of Indians would always remain small.

He considered that schemes B and C would be suitable for all requirements, military and civil, for the medical work in India.

(General Hendley.) He saw no way to get over the difficulty with regard to Indian medical officers attending the wives and families of European officials, if the civil part of the new service became Indianised. He did not think that the building up of a large Women's Medical Service in India would meet the difficulty, as it would not be big enough. He saw no objection to such a service (if established) consisting of Indians. There were no Indians just now available for such a service, as a qualified Indian lady doctor was a rarity. He did not think that she would take the place of the European medical officer.

He had noticed a great deal of difference between the temporary commissioned Indian medical officer and the regular officer. The former was not sufficiently trained. They differed very much from the Indian who had been properly trained in the Indian Medical Service. The difference was entirely a matter of training. He thought that very few of the temporary commissioned Indian medical officers profited from the training they received at the station hospitals, as there had not been very much time to train them thoroughly. A few of them were very good, but the great majority of them were not.

European medical officers had been very much overworked all over India, in the civil service, owing to the shortage of European doctors, as the Indian could not be trusted to do the work.

With regard to his suggestion to help Indians to go to England for the competitive examinations, his idea was to let the schools nominate promising students, to

whom scholarships would be granted, say, about the middle of their career. With regard to the difficulty of recruiting for a purely civil service, he did not see why any European should come out to India in the civil service, when he could get lucrative practice at Home. He did not think that even the question of emoluments would prove a sufficient inducement.

(General Giffard.) He thought that the suggestion (made by the President) of a local Royal Army Medical Corps for Indians would have the effect of causing such a service to be looked down upon as a secondary corps.

He thought a purely Indian civil medical service would sink to the level of the smaller Colonial services, which had not attracted the same stamp of officers as the Indian Medical Service.

He did not see what attraction there would be for men in England, who were much better off, to join a purely Indian Imperial civil service.

He thought that, supposing schemes B and C were adopted, the variety of attractions attending such a service would greatly help in recruiting.

He admitted the difficulty in respect to Indians entering the medical service in the officers' grades, owing to their having to go to England to compete. This difficulty could only be got over by a scholarship scheme for selected men. With regard to the difficulty of the man who had paid for his own education in London having to compete with the man who had been subsidised by the Government of India, he thought it would be a question of the number of those who were available to compete. If a sufficient percentage were able to compete without the State scholarship, Government need not go to the expense.

If Government agreed to grant scholarships, he would favour the idea of this help taking the form of an out-right gift rather than of a loan.

20 February 1919.]

Lieutenant-Colonel J. W. LANGSTAFF.

*(The schemes and questions referred to by witnesses are contained in Volume III.)***At Delhi, Thursday, 20th February 1919.****PRESENT :****S. R. HIGNELL, ESQ., C.S.I., I.C.S. (Presiding).****MAJOR-GENERAL G. CREE, C.B., C.M.G., A.M.S.****MAJOR-GENERAL P. HEHIR, C.B., C.M.G., C.I.E., I.M.S.****MAJOR-GENERAL H. HENDLEY, K.H.S., I.M.S.****THE HON'BLE MAJOR-GENERAL G. G. GIFFARD, C.S.I., I.M.S.****LIEUTENANT-COLONEL A. SHAIRP, C.M.G., Indian Army.****LIEUTENANT-COLONEL G. B. A. RIND, Indian Army.****MAJOR A. A. MCNEIGHT, I.M.S. (Secretary).****LIEUTENANT-COLONEL J. W. LANGSTAFF, D.S.O., R.A.M.C., Assistant Director, Medical Services, Army Headquarters, India.****Written statement.**

The following are the defects which I have noticed in the organisation of the Royal Army Medical Corps and Indian Medical Service:

(1) Officers.

(a) The exclusiveness of the duties of both services and the lack of opportunity for Royal Army Medical Corps officers to become acquainted with the administrative and executive duties of the Indian Medical Service; this also applies, to the Indian Medical Service officer as regards the duties of the Royal Army Medical Corps in India.

(b) Royal Army Medical Corps officers having to perform the duties of Staff Medical Officers and Assistant Directors, Medical Services with little or no experience of India and very little knowledge of the regulations of the Indian Medical Service.

(c) Indian Medical Service officers serving for long periods in civil and getting out of touch with military administration.

(2) Assistant surgeons.

The present very unsatisfactory position of the assistant surgeons employed in British station hospitals.

They do little or no professional work; the senior members do clerical and quartermasters work almost entirely and the junior members little more than wardmasters of the Royal Army Medical Corps.

(3) Nursing orderlies.

Unsatisfactory owing to constant changes and the men employed as such reverting to duty when they wish.

They are not under the officer commanding of the hospital for discipline.

(4) Clerical staff (writers).

Writers should have some training, instead of having to learn their work when taken on as part of the hospital establishment.

2. Either of the schemes B, C or D would go a long way to remedying present defects; of the three, I prefer scheme D, with certain modifications, for the following reasons:—

- (i) It provides a unified service without excluding the Royal Army Medical Corps from India.
- (ii) It provides for a reserve.
- (iii) It restricts the number of Indian Medical Service that can transfer to civil and provides for them keeping up their knowledge of military work up-to-date.

(iv) The scheme should be workable without much dislocation of the present military medical arrangements in India.

3. I would suggest the following modifications in scheme D:—

- (i) That Army Medical Service and senior officers of the Royal Army Medical Corps (lieutenant-colonels and majors) be gradually replaced by Indian Medical Service officers so that eventually the unified Corps is administered entirely by Indian Medical Service officers and only seconded lieutenants and captains of the Royal Army Medical Corps serve in India.
- (ii) Seconded officers to pass in the vernacular within a year and to be available for general duty in India.
- (iii) That all sections of the rank and file Royal Army Medical Corps serve in India for one period of service (*i.e.*, 5—7 years) and that the several sections of the personnel of the "Unified Service," after they have done their recruits' course, are trained under Royal Army Medical Corps non-commissioned officers at the various British station hospitals.

The clerical and quartermaster sections of the Royal Army Medical Corps could subsequently be dispensed with, but I am doubtful if the nursing section of the "Unified Service" can ever attain to the standard required of the Royal Army Medical Corps nursing orderly.

4. I think the War Office would agree to scheme D, as it stands, but I am doubtful if they will agree to the modification I suggest, *i.e.*, the gradual replacement of Army Medical Service and senior Royal Army Medical Corps officers by officers of the unified Corps.

I consider the scheme would meet the needs of the army in India.

5. The question as to whether this scheme will attract a good stamp of recruits and meet the demands of professional opinion in England and India will, I think, entirely depend on—

- (a) Pay.
- (b) Pension.
- (c) Leave.
- (d) The status and percentage of Indian Medical Officers it is decided to admit into the Unified Service.
- (e) Prospects of employment in civil.

6. The result of the withdrawal of European medical officers has been as regards the officers (and families) of regiments, unsatisfactory; speaking generally, they

20 February 1919.]

Lieutenant-Colonel J. W. LANGSTAFF.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

do not like having Indian medical officers to look after them.

7. In order to provide a sufficient military reserve, in addition to the reserve as laid down in the scheme, I would recommend the formation of a special reserve from the civil practitioners (European and Indian) living in India. They should have military training on the same lines as the Royal Army Medical Corps (Special Reserve).

8. I think a reserve medical service with some military training necessary, and that it is advisable that such reserve should be always present in India.

9. The system of education and recruitment for medical officers should be as at present, all candidates to be *vised* by a Board of three senior officers who should satisfy themselves that the candidates are socially fitted for the service.

10. If captains have to pass an examination for promotion to major as in the Royal Army Medical Corps and have a course of nine months at the medical college I do not consider study leave necessary, but it should be left open for the Director General, Indian Medical Service, to grant study leave—up to a year—in special cases.

11. I consider that a college for teaching and research on similar lines to the Royal Army Medical College is necessary.

Medical stores.

12. I consider that all drugs, dressings and medical and surgical material for use in station hospitals should be supplied from Government Medical Store Depots. Officers commanding hospitals should not, except in case of emergency, have to purchase anything.

I think, if it were possible, that it would be more economical if officers commanding hospitals sent in an annual estimate of their requirements and could put in quarterly indents.

The quality of some of the dressings is not up to the standard supplied in England.

13. The role at present filled by military assistant surgeons in British station hospitals is not necessary. I think they are wasted as at present employed. Royal Army Medical Corps quartermasters, warrant officers

and non-commissioned officers could do the duties at present done by assistant surgeons. The one difficulty, in the employment of Royal Army Medical Corps to take over the duties of the Indian Medical Department is the *language*.

The displacement of the assistant surgeon would necessitate a small increase of Royal Army Medical Corps officers for large stations, where it might be considered necessary to have a medical officer on duty in the station hospital and for camps of small bodies of troops usually put in medical charge of an assistant surgeon.

The "Resident Medical Officer work" of the assistant surgeon would be carried out by nursing sisters and non-commissioned officers of the Royal Army Medical Corps.

14. I would suggest that, until the cadre of assistant surgeons ceases, (1) those qualified and recommended be given commissions in the Indian Medical Corps, (2) one senior and one junior be appointed for a term of years (2, 3 or 4) to 1st class British station hospitals to do quartermaster's duties only (Royal Army Medical Corps to be employed in addition), (3) one be appointed to each 2nd, 3rd and 4th class station hospital for quartermaster work only, (4) that one be appointed to each 1st and 2nd class Indian station hospital (*i.e.*, if they are willing), and (5) that more civil appointments be opened for them. I think if this was done and conditions of resignation altered (*i.e.*, retirements allowed in less than seven years) that the present cadre would very soon dwindle away, and by the time (2—3 years) that their work had been learnt by senior Royal Army Medical Corps, non-commissioned officers, the Indian Medical Department would have ceased or very nearly ceased to exist.

15. I do not think that the recruitment of assistant surgeons, as at present educated should be continued. At present they are qualified to practice in India yet do little or no actual doctoring and their position I am of opinion is most unsatisfactory. I would not advocate the continuance of their recruitment even if his education was raised to the standard necessary to obtain a qualification registrable in the United Kingdom, for I think he would be then even more difficult to place than at present.

LIEUTENANT-COLONEL J. W. LANGSTAFF, D.S.O., R.A.M.C., called and examined.

(*President.*) He joined the service in 1899, and had served in South Africa, two years in India, 5 years in England, 3 years in France, returned to India in August 1917.

(*General Hahir.*) He thought that a defect in the organization of the Royal Army Medical Corps and Indian Medical Service was that the officers in the higher ranks did not make themselves familiar with Indians and Indian medical officers in Indian station hospitals and *vice versa*, so as to acquire a knowledge of each other's duties, both administrative and executive. He thought that a blending of such duties would add to the efficiency of both Royal Army Medical Corps and Indian Medical Service officers. If both services were pooled, you would arrive at great efficiency in the higher ranks than existed at present.

He agreed with the suggestion that Indian Medical Service officers, who went into civil employ, acquired a higher standard of professional ability, and that if they were transferred periodically to the military side, it would improve the standard of treatment in hospitals. You would get a greater number of officers with superior medical proficiency.

He did not think that the two months' military training which an Indian Medical Service officer received, on his transfer from the civil side was sufficient.

He thought that the Indian Medical Service reserves were an important asset in mobilisation during the late war. He could not say whether mobilisation would have been seriously affected or not if they had not this Indian Medical Service reserve.

He did not think that the present conditions of nursing in the army in India were satisfactory, with regard to the nursing orderly, as after a man became efficient, he was invariably recalled to his regiment. He would advocate the bringing of the nursing section of the Royal Army Medical Corps to India and keeping it here. He did not think the army authorities would agree to having a nursing corps of British soldiers taken from the army in India and to keeping them in the corps for a certain number of years.

He thought that scheme D would meet all requirements.

He would be inclined to gradually eliminate all except the junior officers of the Royal Army Medical Corps and Army Medical Services from the unified service. It would afford a field for Royal Army Medical Corps seconded officers and after the first or second period of their seconded service, they would decide whether they would belong to one corps or the other. It was practically the same system of service as the Egyptian Medical Service.

He favoured the idea of a Promotion Board, as an institution that would tend to improve the service.

From the point of view of the assistant surgeon, his position in station hospitals, at present, was unsatisfactory. There were many causes of discontent. He thought that making them more highly qualified would make their positions still more difficult and impossible, if they had to continue doing the duties they were performing at present. Even if they were given other duties to perform, such as those of House Surgeons and Physicians, Resident Medical Officers, etc., he did not

20 February 1919.]

Lieutenant-Colonel J. W. LANGSTAFF.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

think their position would be improved, as they would still be warrant officers, and would not belong to any Corps.

(General Cree.) He objected to scheme A on account of the two separate divisions of the service; he meant the auxiliary corps. Even if the status of the auxiliary corps was made practically the same as that of the other officers of the Royal Army Medical Corps he still thought that the auxiliary corps would be looked down upon. There would further be the difficulty about their promotion examinations, as he did not know where they would do that. That was his principal objection to the scheme. He decided that, from that point of view, the scheme would not be feasible.

He did not think it would be detrimental to recruitment for the officers' ranks if junior officers of the Royal Army Medical Corps were seconded to serve in the unified Corps. He thought that they would get

officers who would do one period of five years, but who, perhaps, would not extend their period of service to another 5 years.

(Mr. Hignell.) He thought that scheme D would, as it stood be acceptable to the War Office. The acceptance of scheme A would depend on the difficulties that arose as regards the auxiliary corps. The difficulty to the Indian or Anglo-Indian would, he thought, be a question of promotion and of his promotion examination.

He did not think there was any possibility of the Royal Army Medical Corps being agreeable to open its rank to all British subjects. The reason of this was that there were quite a number of stations at Home where there was only one medical officer, who would have to do general work, that is to say, look after the women and children and everything.

DR. BHAGAT RAM SAWHNEY, M.B., B.S. (DURHAM) RAI SAHIB, Chief Medical Officer, Maler Kotla State, Member Punjab Medical Council.

Written statement.

With the exception of three years service in the Afghan War of 1879—1881, I have all these years had to deal professionally with the civilian community, and that in the Punjab, at first as an assistant surgeon in charge of civil hospitals, then as a civil surgeon in charge of districts in British territory, later on as an independent medical practitioner in British India; afterwards as Chief Medical Officer of a province in the Jammu, Kashmir State, once more as a private practitioner in the Punjab, and finally as Chief Medical Officer of Maler Kotla State. My evidence is therefore based on personal knowledge of the civil medical service and private practice acquired in the Punjab alone. My evidence will be on the following few points :

- (i) The desirability and feasibility of forming a special reserve for war on a large scale, out of the class of private medical practitioners, Europeans and Indians.
- (ii) Raising the standard of higher grade civil medical practice in India by appointing through open competition European and Indian medical men possessing British qualifications and degrees to such high civil posts as may be reserved for them after setting aside a certain number of these posts for officers of the unified Indian Medical Service seconded to civil employ.
- (iii) Raising the standard of medical education (including Public Health) in India to the level of present-day medical educational standard in the west by improving the efficiency of the professorial staff and by creating specialised and research appointments in the Indian medical colleges and hospitals attached thereto.
- (iv) The reconstruction of the Public Health machinery of India.
- (v) Pay, prospects and promotion of the civil medical service.
- (vi) General measures calculated to improve physical stamina of the Indian population.

I. The desirability and feasibility of forming a special reserve for war on a large scale, out of the class of private medical practitioners European and Indians.

From what I personally knew of the independent private practitioners in the Punjab, I think the majority of them, of military age, will be perfectly willing to give an undertaking that they will place their services at the disposal of the Government for employment in the military department in case a war breaks out on a large scale, or, in case of some other grave emergency; provided they are helped in acquiring practical professional knowledge and experience by being attached to different provincial hospitals as honorary physicians, surgeons, obstetricians, gynaecologists and specialists—

positions which are bound to help them in extending and enlarging the fields of their private practice. These men may be given military training for, say, three months after every three years, and if necessary may occasionally be called up for military duty when full pay of their ranks should be given to them. The Government will thus be able to build up a large military reserve which will prove very useful in time of war.

II. Raising the standard of higher grade civil medical practice in India by appointing through open competition European and Indian medical men possessing British qualifications and degrees to such high civil posts as may be reserved for them after setting aside a certain number of these posts for officers of the unified Indian Medical Service seconded to civil employ.

I am of opinion that one-third of the civil surgeoncies in each province should be set aside for officers of the unified Indian Medical Service. The second-third should be reserved for senior assistant surgeons for whom the possession of British medical qualifications should be made compulsory; and the remaining third of the appointments should be filled up through open competition by European and Indian independent medical practitioners possessing British degrees and qualifications.

III. Raising the standard of medical education (including Public Health) in India to the level of present-day medical education in the west by improving the efficiency of the professorial staff, and by creating specialised and research appointments in the Indian medical colleges.

In my opinion medical education in this country requires considerable improvement. It ought to be improved sufficiently to bring it up to the level of medical education in the west. There is plenty of material for this purpose in the country. I would beg to suggest the following changes which I consider very necessary. The professors should not be recruited from the military services but medical men with superior British qualifications and some teaching experience alone should be selected. They should remain attached permanently to colleges. The professorial staff should be increased. Posts of assistant professors who will also be assistant physicians, assistant surgeons, assistant obstetricians, and gynaecologists to the hospitals attached to the medical colleges, should be created. When vacancies occur assistant professors should be eligible for full professorships and their places taken by chief clinical assistants and registrars which posts shall also have to be created. In fact the same system should be introduced here as is in force in England, i.e., a man should rise in the college or hospital itself from the lowest to the highest rung of the ladder. In this way he will be from the beginning in touch with the teaching line. Of course for the present professors and assistant professors must be men trained and

20 February 1919.]

Dr. BHAGAT RAM SAWHNEY.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

qualified in England and not those who have spent six months or a year in England, and got some sort of qualification. It is only under such an arrangement that medical education in India will be as good as in any other country. The professors should not be made to retire at the age of 55. The age should be increased to 60 and in case of men healthy and able to work, even to 65. The more experienced the man the better he will be able to teach. In every Indian medical college there should be a chair of pharmacology, as there are in India, a number of indigenous drugs some of them very efficacious, and at the same time very cheap, of which the pharmacological action ought to be studied very thoroughly.

Then in connection with the medical colleges and hospitals attached thereto, there ought to be created a number of special branches such as that of skin diseases, nervous diseases, urinary diseases, electrical therapy, orthopaedic departments, etc. We must realise that there are no special hospitals in India as there are in England where the students can go for a special training in these and other special branches of medical science according to their individual inclinations. Hence all such arrangements should be made in the medical colleges and hospitals attached to them. Should the Government be not willing to spend so much money on the creation of these special branches of medical study and practice, then properly qualified and trained honorary specialists must be appointed. Of course properly equipped laboratories, etc., will have to be attached to the teaching institutions.

I might say specially that the professor of midwifery might be a European. He may have an Indian assistant professor. In all large cities where there is a big European population it is necessary to have a European accoucheur and gynaecologist.

It would be better if the administration of the hospital and college were entrusted to a board composed chiefly of professors with one or two other medical men outside the professorial line. There should also be arrangements for a D. P. H. course in the medical colleges of India. In the Punjab the Health Officer of Lahore could give the students the practical training required.

Arrangements for research work should be made by fitting up proper laboratories, etc., in connection with medical colleges. In Europe a lot of research work is done by teachers in medical schools. The above arrangement of selecting the staff of the college will stimulate research work. But if the Government has special research workers who are paid well so much the better. Naturally those teaching pharmacology, pathology and physiology will not practice and will thus devote their spare time to research work if they are provided with properly fitted laboratories. There should be a research fund administered by a board and it should give grants to those who wish to carry on any particular research. For young energetic capable men there may be research studentships and scholarships tenable for a certain period, which may be renewed if necessary. This is the only way to stimulate desire for research work.

IV. Reconstruction of the public health machinery of India.

The sanitary service should be greatly extended and much better paid than it is at present if the work is to be done more efficiently. It is impossible to have health officer on hundred and fifty rupees a month,

and expect him to do full justice to his work in a big place like, say, Rawalpindi. Cost of living in these days is high, and besides a health officer must keep up his position.

Every district board and municipality must have a health officer. In places where the municipality and district board cannot afford to keep separate health officers and pay them adequately it is better to have a joint health officer of the municipality and board.

All health officers should be in possession of the D. P. H. with western professional and social training. Under the health officers there should be properly trained sanitary inspectors to do most of the routine work.

Of course the sanitary commissioners of provinces and deputy sanitary commissioners will be appointed by Government. The sanitary commissioner should be an officer of unified Indian Medical Service, and must necessarily possess a D. P. H. qualification. The deputy sanitary commissioners should all be Indians who alone have an intimate knowledge of the people and the conditions under which they live and are consequently best fitted to work out the sanitary salvation of their country. The posts of deputy sanitary commissioners and health officers ought to be pensionable. If there are to be no pensions then they ought to have a provident fund.

V. Pay, prospects and promotion of the civil medical service.

Here there should be a general improvement of the hospitals in the district headquarters and other large towns. Honorary physicians and surgeons and in important places like Amritsar, Rawalpindi, honorary specialists should also be attached to these institutions. Of course the honorary staff should not only have charge of out-patients but of in-patients as well. The pay, prospects and promotion of the civil assistant surgeon class ought to be improved. The starting pay of an assistant surgeon should be rupees two hundred a month and the maximum pay not less than rupees four hundred.

As already said, one-third of all civil surgeons in a province should be within reach of the senior and capable civil assistant surgeons on whom the possession of British qualifications or degrees should be incumbent until such time as medical education in India is brought to the level of Western standards. For the purpose of qualifying in England they should be granted study leave. Similarly pay, prospects and promotions of the civil sub-assistant surgeon class should also be improved. The starting pay of a sub-assistant surgeon should not be less than rupees fifty and the maximum pay not less than rupees one hundred and fifty.

VI. General measures calculated to improve the stamina of the Indian people.

Personal, domestic, and civil hygiene should be scrupulously taught in all primary and secondary schools in this country. The terrible devastation caused by the recent pandemic of influenza has made us all painfully realise that side by side with mental development of the entire Indian population should go the physical development of the urban people, whose physique and health we find, have deteriorated considerably. For the attainment of this object, among other things, a fuller economic development of this country which is now, in effect, a part and parcel of the world would be essential.

Dr. B. R. SAWHNEY, called and examined.

(Mr. Hignell.) Under the scheme outlined in his written statement he contemplated a more or less separate organisation to meet the military and civil needs.

(General Hendley.) Provided the private medical practitioners were given some military training they could form a war reserve. He could not say how many private practitioners in the Punjab had volunteered for field service. Some had volunteered for military service and he presumed that they were liable to be

sent out of India. He himself had served in the Afghan war of 1879. Even assuming that none had volunteered for active service in the field in this war he thought that Indians, if properly treated and helped, that is, if they were organised on a military basis and were allowed to gain experience in the hospitals, would come forward for field service in future wars. They would under these circumstances be prepared to give an undertaking to join for general service and would be willing to throw away their private practice. The

20 February 1919.]

Dr. BHAGAT RAM SAWHNEY.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

reason why they did not do so in this war that they did not clearly understand the position.

For appointments to professorships in the medical colleges men should rise in the college or hospital itself from the lowest to the highest rung of the ladder. They should start as clinical assistants or demonstrators, should then become assistant professors and should eventually become professors. These men should hold whole-time appointments. He was of opinion that it was good for the professors, and for the students, that the former should devote their whole life to this sort of work. The more time a man spent in teaching the more efficient did he become. No doubt such men would have more experience of teaching than of professional work, but the latter would be provided in the hospitals attached to the colleges.

Men holding appointments in the Sanitary Department were not sufficiently paid. The pay in all the Health Departments was very insufficient.

All the health officers should have Western professional and social training. At present he would not give such appointments to persons with purely Indian qualifications unless they had been to Europe and studied the systems of sanitation there.

(General Hehir.) The conditions that would induce Indian private practitioners to join the war reserve would be the grant of the same pay, rank, etc., while in military employment, as that given to military medical officers. Another inducement would be that they should be appointed as honorary physicians and surgeons to provincial hospitals. This would cost nothing to Government but would enhance the status of these men and thus help them in their practice and bring them in more money. He admitted that such a condition, as an inducement to join the war reserve, was unheard of anywhere else, and that men joined the reserve on patriotic grounds, but thought that the conditions in India were different and people required to be taught patriotism. Under these circumstances some

inducements were essential. The grant to them of the right to use their rank or wear their uniform on special occasions might go some way to induce some men and a retaining fee or bonus might also prove helpful.

With reference to the statement that in the Punjab there were very few private practitioners who had volunteered for field service, he pointed out that his own son who had obtained the M. B. degree at Cambridge and was a specialist in eye and urinary diseases and who could talk French and German besides English had volunteered himself and had been put in charge of a venereal hospital at Meerut.

(General Cree.) The scheme outlined in scheme A under which there would be an auxiliary corps of the Royal Army Medical Corps, which would consist of Indians and Anglo-Indians, and would be called the Royal Army Medical Corps, and would have all the privileges of rank, promotion, pay, etc., of the Royal Army Medical Corps, and the members of which would normally be employed in India or wherever the Indian Army is employed, would be acceptable to Indians, as the suggested auxiliary corps was to be in no way inferior to the Royal Army Medical Corps. It would have no deterring effect on Indians if a condition were laid down that the members to this auxiliary corps might be called upon to serve in any part of the Empire in case of emergency.

(Mr. Hignell.) The sanitary service outlined in his written statement might either be a distinct service or part and parcel of the general medical service. The deputy and assistant sanitary commissioners and health officers should be Indians, as they would be familiar with Indian conditions and would better be able to minister to the needs of their own countrymen. Knowing the special insanitary conditions they would better be able to cope with them than the Europeans whose mode of living generally differed from those of Indians.

DR. CHAUDHURI MELA RAM, B.A., M.B., Civil Assistant Surgeon, North-Western Railway, Lahore (nominated by the Punjab Medical Council, to represent Civil Assistant Surgeons of the Punjab).

Written statement.

The present war has shown that the old system of having a military medical reserve is inadequate and cannot be depended upon in times of a great crisis.

The wars of the future in which the British Empire may be compelled to take part will not be child's play and unless practically the whole medical profession of the country is prepared to take part in the gigantic struggle medical administration and relief can never be adequate to meet the needs of the forces in the field.

The transfer moreover of the military medical men almost wholesale into the civil side leaves either only junior or inferior men in the military and those transferred to civil after a time lose all military instinct and interest in special military medical science and at a time of crisis it becomes difficult to obtain a proper solid nucleus round which to build a complete medical organisation. A further increase of the present reserve system, without being of any material help, will make the Indian medical education still more unpopular and will draw only material of the most inferior kind into the profession.

Total strength of the civil assistant surgeons	685
Superior appointments held by civil assistant surgeons	40
I. M. S. sanctioned strength	748
" rolls of enlistment	772
" civil appointments held	475
" military appointments held	297
New proposed strength on basis of 3 per mille	1,000
Proposed increase of reserve	252
Military assistant surgeons	713
" in civil employment	289
" in superior appointments	53

The above figures show that even if all the superior appointments (40) were taken away, they will not be enough for a further proposed increment of 252 in the Indian Medical Service alone. The amalgamated service requires an increase larger than 252. How is their reserve, therefore, to be posted on the civil side.

This moreover leaves no room for increasing the reserve of military assistant surgeons. The present war has further shown that even such an increase (252 in 772) is not adequate. Over 800 graduates of Indian universities were given commissions, i.e., about 105 per cent. of the Indian Medical Service strength. They were chiefly drawn from amongst the assistant surgeons, permanent and temporary. Is it not rather miraculous that a total permanent strength of 685 should yield at a pinch over 800 men, who let it be said to their credit, without any special training worked very satisfactorily. The Punjab has only 105 permanent appointments for assistant surgeons and 17 temporary appointments. For these appointments it has 110 men on the temporary list; from this strength it gave 105 temporary Indian Medical Service officers.

It is from this service that the only 40 appointments of a superior nature are proposed to be taken entirely or partly. Medical line is already unattractive. If university results were scrutinised it would be found that it is rare that the topmost men ever come to the medical line. As a rule such students take to the provincial civil service, law, engineering, etc., where prospects are considered better.

Moreover, medical men as a rule have abstained from sending their children into the line which means dissatisfaction with remuneration in the line. A few cases that are to be found are only of sub-assistant surgeon.

20 February 1919.]

Civil Assistant Surgeon CHAUDHURI MELA RAM.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

sending a son to assistant surgeon classes or an assistant surgeon a son for the Indian Medical Service, but even such cases are extremely rare.

Military medical service.—The military medical services should be unified by the fusion of Royal Army Medical Corps and Indian Medical Service and Indian subordinate medical department. This unified service should be a purely military service.

Recruitment.—It should be divided into superior and inferior.

Superior.—The recruitment for superior service as at present for Royal Army Medical Corps and Indian Medical Service is by a competition in England. 33 per cent. of the appointments should be recruited in India by a similar competitive examination as foreshadowed in the Montagu Chelmsford reform scheme rising by $1\frac{1}{2}$ per cent. till next commission.

Those recruited in England should immediately proceed to India and receive their military training at the Royal Army Medical College to be started on the lines of Millbank and Aldershot.

Those recruited in India should proceed to England and receive their military training in England, where they can also undergo a short course in practical midwifery if it is considered that India does not afford sufficient material for such practice at present.

Inferior medical service.—These should also be recruited both in England and in India.

The minimum qualifications to be the same, i.e., qualifications registrable under the British Medical Council.

Competition would not be needed.

Designations.—The members of superior medical service should be called lieutenants, captains, majors, etc., as at present. Inferior service men should have the designations as of warrant officers and Indian commissions. Both these services should be purely military and form in times of war a nucleus round which the civil reserves would crystallize.

The system, however, should not be rigid; sufficient elasticity should be given to it to permit persons both of the superior and inferior service to be transferred to civil for some special reasons and if permanently transferred, should drop their military designations and be absorbed into the civil medical service of the country and form a part of the military reserve like the civil medical service.

Civil medical service.—All civil appointments, administrative, tutorial, technical, medical relief, sanitary, jail, etc., should be filled by the civil medical service of the country. It should also be superior and inferior like the military. Both should be liable to military service in times of need.

Superior.—It should be recruited by open competition in England.

Recruitment.—33 per cent. as foreshadowed in the Reforms Scheme should be recruited in India by a competitive examination. Like the military superior service they should also receive a preliminary training to fit them for military work and like the Indian graduates should proceed to England for military and social training. Europeans entering through Indian competition need not be sent to England unless they so desire.

Those getting appointments in England should come over and receive both their military and social training in India and language. Indians getting appointments through England need not be immediately sent to India. They might get their training there if so desired.

Inferior service, civil.—All appointments in the civil now held by the assistant surgeons both civil and military should be filled by this class.

The minimum qualification should be the same, i.e., registrable under the British Medical Council.

Recruitment.—They should be either by competition or by nomination. In the latter case the top man should be taken first if they so desire.

Europeans and Anglo-Indians entering this service should receive their military training in India. Indians,

however, may be encouraged to go to England, and therefore study leave to Europe should be given to men in this service like the superior service earlier or after 5 years' service.

Those in this service, on obtaining special qualifications and being found specially deserving, may be promoted to the superior service after 10 years' service. Promotion to the superior service after 20 years' service should be only in exceptional cases.

Appointments in superior service requiring active outdoor life should never be given after 20 years' service in the inferior service.

Tutorial appointments like professorships of colleges should be advertised and men most suitable for the work selected from amongst the various services in India or from private practitioners in England or India. These appointments should be probational for two or at the most three years after which it should either be confirmed or a new candidate appointed. The decision should rest with a council of educationists all of whom need not be medical men.

I would suggest that students should to some extent be consulted. They have very often a shrewd idea of the capacity and suitability of a professor. A renowned surgeon or physician need not always mean a good professor of surgery or medicine. Assistant professors should also be specially selected from junior members of the service or from independent practitioners both in India and in England, and under suitable circumstances promoted to be professors. Demonstrators may be taken from the superior or inferior service and suitable men may rise to be assistants or full professors.

In the interest of the future of medical science and medical services, it is necessary that a thorough overhauling of the educational colleges should be undertaken. The appointments should not be the monopoly of any special service whether military or civil.

All tutorial appointments should bear permanent emoluments such as to attract the best men from all parts of the British Empire, if not the whole world. All classes of qualification below the minimum should be abolished. Candidates from all classes, without distinction of colour, creed or race should receive the same education.

If needed, a slight difference of preliminary qualification may be permitted for the licentiate and degree classes as a temporary or permanent measure, but the minimum should be so high that students can follow the subjects rationally and not get them up by rote.

This will produce an *esprit de corps* amongst all classes of medical men, and greater cordiality between different classes of His Majesty's subjects. Denominational institutions propagate caste and creed distinctions. All patients like to have the best man to relieve their sufferings. Some Europeans have very lucrative practice among Indians (Indians who only half a century ago would go and wash themselves clean) and a number of Indian doctors have their chief field of practice among Europeans. These differences are fostered by short-sighted people.

If a few members of the Indian Civil Service or other services have such exclusive prejudices they cannot and should not be permitted in the way of Indian medical progress. The fewer such persons take to Government service the better for the good government of humanity.

Moreover this scheme even if taken in hand immediately will not affect the personnel of the present office-holders and for the future, knowing the condition of mixed medical services in India, men will come with open eyes and in fact Government could institute a kind of agreement that the party holds no such prejudices.

How to induce private practitioners to enter the war reserve.

Only men with registrable qualifications to be taken.

(1) They should be offered a small retainer.

20 February 1919.]

Civil Assistant Surgeon CHAUDHURI MELA RAM.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

(2) All who are on the war reserve list should be exempted from Arms Act.

(3) They should have free access to Government clinical and bacteriological laboratories.

(4) They should have free permission to use state or public hospitals for surgical and clinical works.

All these concessions would be appreciated by the private practitioners and (3) and (4) will keep them up to date.

They will have to undergo military training. In time of need, younger men will be required to go on active service, but senior men could be utilised to release civil medical service men for military duty.

DR. CHAUDHURI MELA RAM, called and examined.

(Mr. Hignell.) He was educated in the Lahore Medical College. He passed out in 1899. He was the first student of his year, and was taken on as an assistant surgeon in the same year. He remained in charge of various dispensaries up till 1914. At the end of 1914 he was placed in charge of the civil dispensary at Lahore. At the beginning of 1915 he was officiating civil surgeon of Dharmasala. He was two years in Dharmasala and was then transferred to Montgomery and from there he reverted as assistant surgeon of the North-Western Railway. He had not seen any military service though he offered his services very shortly after the outbreak of war. He was 41 years old when he volunteered.

(General Giffard.) With regard to the appointment of professors in the medical colleges, he was of opinion that men selected for these posts should be on probation first and if found suitable confirmed. Their selection for confirmation as professors should be carried out by a committee of educationalists. The students of a college should also be consulted when an appointment of this nature was being made as they sometimes had a shrewd idea of the capacity and suitability of a professor.

(General Hendley.) He did not know of any Indian civil assistant surgeons and senior assistant surgeons who had volunteered for military service though he had offered his own services on two occasions. On the latter occasion he stipulated that, as a condition of his services being utilized, he should be given a permanent commission as a lieutenant in the Indian Medical Service, or that having regard to his seniority he should be made a temporary captain. He said that if neither of these conditions were granted his seniority should be taken from the date on which he first offered his services. He would not mind being a temporary captain and drawing the pay of a lieutenant. He had received no reply to the offer of his services on these conditions.

With regard to the first inducement suggested in his statement to attract private practitioners to enter the war reserve, he was of opinion that they should be given Rs. 30 or Rs. 40 per mensem to compensate them for the loss of private practice.

(General Hehir.) If an increase is desired for the peace time cadre of the military medical service this should be obtained by sending fewer officers to civil, or by withdrawing men who are now in civil employment.

With regard to the grant of scholarships to enable men to proceed to Europe to study he was of opinion that they should not be granted to students but only to qualified men, who proved successful in a competitive examination, held in India, for entrance to the medical service.

He would not like to see the Indian Medical Service officers in civil employ swept away at once. This should be done by degrees, as officers retire, give up their appointments, etc.

It would be in the interest of the army if some men went into civil and then reverted to military, after a short period, but if any remained in civil for any length of time they should remain there and not be transferred to military as they would be useless.

Indian medical officers would resent a restriction preventing them from looking after the families of British officers and soldiers. They would also resent it, if they were not allowed to command British station hospitals. Europeans in India were responsible for the prejudices that existed against Indian doctors treating them and their families. He mentioned that a number of his personal friends were practising in England in commercial districts and they were all doing well. There were no prejudices against them in England.

(General Cree.) He thought that the proposed auxiliary corps (scheme A) would prove attractive to Indians even if the War Office reserved to themselves the right to send the officers of this corps for service in any part of the world. If Europeans were excluded from this Corps he thought it would be looked down upon to some extent.

He, however, thought that if the Royal Army Medical Corps altered their charter and admitted to the service all British subjects, who would then have to serve all over the British Empire very few Indians would enter it, because of their disinclination to serve so far from their homes. Some Anglo-Indians would, however, enter it, even under these conditions.

Civil Sub-Assistant Surgeon LALA KHAZAN, CHAND RAI SAHIB, M.P.L., Central Malaria Bureau, Kasauli, Provincial Secretary (Punjab), All-India Sub-Assistant Surgeons' Association.

Written statement.

Are you satisfied with your present position as an Indian warrant officer? If not, give reasons.

No; we are not at all satisfied with our present position as "Indian warrant officer" on the following grounds:—

- (a) The rank of "Indian warrant officer" does not exist in the Indian Army and is therefore anomalous in the case of sub-assistant surgeons. It does not command respect and the sub-assistant surgeon finds it difficult to maintain discipline in the hospital.
- (b) The warrant rank attaches itself to the sub-assistant surgeon till he is promoted to the senior grade—a period by which time an ordinary sepoy, whom the sub-assistant surgeon had examined for physical fitness

when being enrolled in the army and who had perhaps served as an orderly in the hospital, reaches the jamadar's rank and becomes his superior and demands a salute from the sub-assistant surgeon.

- (c) The general educational and professional qualifications combined with the social position of the sub-assistant surgeon demand that he be ranked as jamadar from the beginning of his service.
- (d) The starting pay of a sub-assistant surgeon, although it is not what it should be in consideration of his educational qualifications, is about the starting pay of a jamadar, and this itself entitles him to an Indian commission; it is indeed anomalous that sub-

20 February 1919.]

Civil Sub-Assistant Surgeon LALA KHAZAN CHAND.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

assistant surgeons of the 2nd and 1st grades drawing higher rates of pay (*i.e.*, Rs. 75 and Rs. 95 respectively) be considered inferior to a jamadar drawing Rs. 60 only.

Do you consider that study periods would be important to your branch of the service, and if so, should they be taken in (a) existing medical colleges and (b) a proposed new military medical college in India?

Study periods would be of undoubted importance and value to my branch of service. They are indeed very essential. They may be taken in the existing medical colleges as well as in the proposed new military medical college, but what is of still greater importance, the members of my service must be given wide choice in this respect. In addition to the above they should be given every facility, if for instance they have special aptitude for any of the following:—

- (a) A short course at the Calcutta Tropical School.
- (b) Longer course at the Calcutta Tropical School.
- (c) Courses at the Bombay Tropical School (when established).
- (d) Course of clinical bacteriology at the Central Research Institute.
- (e) Course of malarial training at the Central Malaria Bureau.
- (f) Course of instruction in X-Ray and Electric therapy at Dehra Dun.
- (g) Courses in other special subjects like ophthalmology, throat diseases, dentistry, pathology, gynaecology, etc.

Sub-assistant surgeons should be entitled to one year's study leave for this purpose. Post-graduate study would beyond question constitute a very important addition to their professional knowledge. Any member of this service desirous of prosecuting further study in the United Kingdom to be given suitable concessions.

Grade examinations should be entirely abolished. It is indeed a slur on the profession that orders like the dismissal of sub-assistant surgeons failing to pass in the successive grade examinations be issued, when in addition to their having passed the medical school examinations for four successive years, sub-assistant surgeons have at their back practical professional experience extending over several years.

Questions for Military and Civil Sub-Assistant Surgeons.

Should the Local Government decide to throw open civil appointments to a large number of military sub-assistant surgeons do you think such appointments will be popular and sought after?

Yes; they will certainly be sought after by the military sub-assistant surgeons, but members of the civil department will naturally and I might also add justly have a cause of complaint, as they are already for no fault of theirs being deprived of the fruits of their labour, *i.e.*, important dispensaries which they popularised after a hard and persistent toil for years together and of which they held charge with credit to themselves and the profession they belong to, are now being taken away from their hands, especially at a time when their preliminary educational and professional qualifications are admitted to be higher than what they were before. It is therefore very essential that members of the class which has been so largely instrumental in diffusing the knowledge and benefits of the Western medical science among the masses, and which is rightly styled the "backbone of the medical profession" in India, be in no way subjected to this injustice. If the military sub-assistant surgeons were to be rewarded for their meritorious services, they could be given some prize posts out of those now reserved for military assistant surgeons, or remunerated in several other ways.

Do you consider that military and civil sub-assistant surgeon pupils should have a higher preliminary school or university qualification than they do at present?

The matriculation examination of the Punjab University is a sufficiently high qualification for members of this service, as it is in no way inferior to the preliminary educational tests required of medical students by the General Council of Medical Education and Registration in Great Britain.

What is, however, needed is that (a) the course of study in the medical schools be raised to one of five years, (b) the medical schools be affiliated to the Universities, (c) the degree should be that of "L. M. S.," and (d) the courses of study in the Indian medical schools be recognised in the United Kingdom by the British Universities.

What will be the effect on recruiting for the military sub-assistant surgeons and civil sub-assistant surgeons classes of demanding a security deposit of money before commencing training; which deposit would lapse to Government if the sub-assistant surgeon fail to complete the necessary five years' service?

Nothing is more advantageous to science than open competition. The chief aim before the medical service is to secure the best "Doctors" and any check such as security deposit would decrease the field of recruitment. As such as I am in favour of open competition as against security deposit, which would affect recruiting in so much as it would prevent the service from availing itself of the right type of men. Recruiting for the best type would thus suffer besides being much unpopular.

The functions of the medical schools and colleges should be to impart medical education only, having nothing to do with recruitment as in Great Britain. The recruitment of all services should be done by open competition as in Great Britain.

Is the bond now signed satisfactory, under which civil sub-assistant surgeons may be drafted to military employ during or after five years' civil service?

I do not consider the bond system to be satisfactory; it should better be dispensed with, and a special "war reserve" of civil sub-assistant surgeons be created by paying them a "retaining fee."

Is service with the army under present conditions satisfactory to civil sub-assistant surgeons, and if not, what remedies do you suggest?

No; service with the army under present conditions is decidedly far from satisfactory. The civil sub-assistant surgeons when taken on military duty, should be given the pay, prospects and all other privileges of military assistant surgeons and be designated as military assistant surgeons. They should, in addition, receive the Indian commissions up to first grade (*i.e.*, Jamadar for 3rd grade, Subadar for 2nd grade, Subadar-Major for 1st grade) and after that honorary British commissions while serving in the Indian Army.

If Government propose that all civil sub-assistant surgeons should undergo a course of military training, will this be popular in your department and will it affect recruiting?

A course of compulsory military training for all civil sub-assistant surgeons is not likely to be popular and will have a deleterious effect on recruitment. It will be advisable that military training be confined to the special war reserve which should be created in the ranks of civil sub-assistant surgeons by paying them a "retaining fee."

Are you satisfied with your present scale of pensions?

Certainly not; the present rate of family pensions for military sub-assistant surgeons (*i.e.*, Rs. 12 to Rs. 15 for third, second and first class men, and Rs. 20 to Rs. 25 for seniors) is too low to allow the dependents of sub-assistant surgeons to keep their bodies and souls together; in these days of high prices, which to all appearances seem to have come to stay, the sum of rupees twelve is not sufficient to purchase *atta* alone to satisfy the needs of an average family of a sub-assistant surgeon, not to speak of other necessities of life, clothing and other expenses to meet other emergencies like illness etc.; to

20 February 1919.]

Civil Sub-Assistant Surgeon LALA KHAZAN CHAND.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

think of education of children under such circumstances is a mere dream.

Half the pay of sub-assistant surgeons' grade in which he was serving at the time of death in the battle field or in an epidemic may be given to his dependents, and three-fourths in the case of wound and injury pensions.

Do you consider that there should be a scheme of pensions for widows and orphans of both military and civil sub-assistant surgeons, if so, would the sub-assistant surgeons be prepared to contribute?

Yes; I am pretty certain that the members of my service would not be unwilling to contribute towards a scheme of this character; I have studied the one for members of the Indian Medical Service, and consider that a scheme on somewhat similar lines be created for the sub-assistant surgeons; it is sure to meet with general approval.

Are there any other specific disabilities in your service which you desire to bring to the notice of the Committee?

Yes; there is indeed a long list of grievances under which the members of my class are labouring, and I feel that I shall be rendering a great disservice not only to the members of my own class, but to the Government as well who have kindly offered us this opportunity, if I failed to bring at least a few of the most important of these grievances to the notice of this august body.

(a) The present scale of pay of sub-assistant surgeons is extremely low as compared with men of similar qualifications in other departments. In view of the more efficient and costly training of the present day sub-assistant surgeon, the general rise of the cost of living and the general movement of the times, the scale proposed below would seem to be very cautious as well as modest:—

	Rs.
3rd grade sub-assistant surgeon (1 to 5 years' service)	75
2nd grade sub-assistant surgeon (6 to 10 years' service)	110
1st grade sub-assistant surgeon (11 to 15 years' service)	150
Senior grade sub-assistant surgeon (after 15 years)	200
Special grade (2 per cent. of the total strength) (over 20 years' service) 250—10—300	

I would like to mention that military assistant surgeons with almost similar qualifications as those possessed by sub-assistant surgeons start on a pay of Rs. 100 per mensem and can rise to the grade of Rs. 700. Civil assistant surgeons who have a slightly higher preliminary standard of education and a year's additional course of professional training, start on Rs. 100 and can rise to the grade of Rs. 500.

(b) *Promotion.* In respect of promotion to the higher ranks of service the sub-assistant surgeon class differs entirely from every other department of Government service, as truly observed by the Bengal Government. While in other departments of Government service an officer could reasonably hope to rise by efficient and honest discharge of duty from the lowest to the highest position, and good and meritorious services are almost invariably appreciated and rewarded by special appointments created for the purpose, the door of future progress is practically entirely closed against the members of this class. While members of the sub-assistant surgeon class can be promoted to the ranks not only of assistant surgeons but also to the rank of civil surgeons and are in fact ably and efficiently discharging the duties as district medical officers in other provinces, the members of my class in the Punjab also are reasonable in expecting that their case also should be liberally considered in the matter of promotions to higher ranks. It will not be out of place here to give the opinion of the head of the local government in our province about the work of a member of my class. Referring to his work His Honour said:—"The record established by, a sub-assis-

tant suregon, is truly wonderful, and his popularity strains the resources of the dispensary, where notwithstanding the praiseworthy efforts of his patients and the men of the surrounding tract, the accommodation provided is only sufficient for one quarter of the daily average attendance of in-patients." Further on he again remarks:—"That such skilful operators should be condemned by our system never to be able to rise above the post of sub-assistant surgeons without going through a college course, is, in the Lieutenant-Governor's opinion, a serious blot on our medical organisation."

The Bengal Government in their note published on page 352, vol. XII of the appendix to the report of the Royal Commission on Public Services in India, referring to sub-assistant surgeons remark:—"There are many competent officers who hold the view that a fully experienced and capable hospital assistant (as sub-assistant surgeons were then called) of the first grade is equal if not superior in usefulness and professional knowledge to an assistant surgeon of the lowest class; and the Lieutenant-Governor would urge the expediency of allowing promotion, etc."

In view of the above facts, it is earnestly to be hoped that the question of promotion of the members of my class to higher ranks of service would in future receive a more sympathetic and liberal consideration.

(c) *Designation.* Until the question of merging the assistant and the sub-assistant surgeons classes into one provincial service is decided, the designations suggested by the Punjab Medical Council appear to be suitable. These are:—

District Medical Officer for civil surgeon.

Deputy District Medical Officer for assistant surgeon.

Assistant District Medical Officer for sub-assistant surgeon.

(d) *Position.* Sub-assistant surgeons to be reckoned as second class officers under the terms of the civil service regulations.

(e) Jail service should be separate from the ordinary service, and the sub-assistant surgeons should be called deputy superintendents of jails.

(f) The curriculum in the Government medical schools is such that they have no prospects of rising to higher grades or to obtain higher medical qualifications. This state of stagnation is incompatible with the healthy growth of the individual and of the profession as a whole. The curriculum of the Government medical schools should be at least so modified as to be similar to the curriculum of the Society of Apothecaries of London and thus be made registrable under the British Medical Act. The Society of Apothecaries imparts four years' medical education in its medical schools like the medical schools of India but it recognises practice of medicine and surgery for one year at a hospital as the fifth year training. Such a modification of curriculum would open higher posts to the licentiates of the medical schools, who at present rot as sub-assistant surgeons all their lives.

(g) The subordinate service and the designation sub-assistant surgeon be abolished altogether. The subordinate service be merged into the provincial service which should be recruited by competitive examination open to all university graduates and licentiates of medical schools. The Imperial service should also be recruited in India to the extent of 50 per cent. in which the licentiates of medical schools should also be allowed to compete.

(h) The designation of military sub-assistant surgeon should be abolished and be replaced by "Military assistant surgeon." At present there is no class of military assistant surgeons in the Indian army and it is therefore anomalous to have military sub-assistant surgeons. They would have Indian commissions from the start up to first grade and above that honorary British commissions as are granted to the Anglo-Indian military assistant surgeons in the British army.

20 February 1919.]

Civil Sub-Assistant Surgeon LALA KHAZAN CHAND.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

(i) Representation of sub-assistant surgeon on medical councils is at present very inadequate and needs substantial increase.

Have you any suggestions to make regarding the present method of recruiting for your service?

There should be only one provincial service for the civil and the other for military, and both should be recruited by competitive examination open to all university graduates and licentiates of medical schools.

As warrant officers have you any difficulty at present in connection with the maintenance of discipline in regimental or Indian station hospitals?

In view of what I have said under my answer to question No. 1, it is of the utmost importance that a sub-assistant surgeon should start his service as an Indian commissioned officer; nothing short of this is likely to satisfy the members of my service. The present status puts a sub-assistant surgeon directly at a disadvantage in maintaining discipline.

What would be the effect on the civil sub-assistant surgeon service of the wearing of uniform and

other military privileges and disabilities that would affect sub-assistant surgeons if they were brought under the Army Act when serving in military employ?

If the civil sub-assistant surgeons be recruited as military assistant surgeons with Indian commissioned rank up to first grade and above that with honorary British commissions and all other rights and privileges of Anglo-Indian military assistant surgeons, they would have no objection to being placed under the Army Act when serving in the military department, but they would never like to serve as military sub-assistant surgeons and as warrant officers.

What would be the effect on the civil sub-assistant surgeon service and on recruitment for that service of making field service in time of war one of the conditions before the employment in the civil medical service?

I should think that there is no necessity of a bond or any other conditions for civil men to serve in field service. A special war reserve of civil men be drafted by payment to them of a retaining fee if they offer themselves for military duty or war service.

Civil Sub-Assistant Surgeon LALA KHAZAN CHAND, called and examined.

(President.) He was provincial secretary of the All India sub-assistant surgeons' association. They had nearly 2,700 members throughout India. He could not give the figures for the Punjab. Each branch of the association was an independent institution but formed part of the whole. He was in Government service, being employed at the Central Research Institute at Kasauli.

With regard to study leave, he favoured a period of one year to be apportioned according to the courses of study.

With reference to his suggestion to create a war reserve of civil sub-assistant surgeons, he would consider a retaining fee of Rs. 30 per mensem, for all grades, sufficient.

(General Cree.) He thought the auxiliary corps, proposed in scheme A would be attractive to Indian doctors. He would also suggest that, as regards recruitment for that service, graduates in medical colleges and schools should be allowed to appear at a competitive examination. He did not think there would be any tendency for that corps to become a subordinate corps and to be looked down upon in consequence.

He did not think that the fact of the War Office reserving to themselves the right of employing this auxiliary corps in any part of the Empire would act as a deterrent to the recruitment of Indians for the service, as the Indian officers would accompany the Indian army wherever they went. Even if, in addition, the corps was taken away from India and employed abroad with a British army, he did not think that that fact would be a deterrent to recruitment for the service.

(General Hehir.) Military sub-assistant surgeons should receive a military training along with their course of study in the medical school, and, as soon as they left school, be given commissioned rank.

Part of the service of civil sub-assistant surgeons could be used to form part of the war reserve by giving them a retaining fee. If they were given all the privileges enjoyed by the military assistant surgeon, such as pay and rank, there would be no objection to compulsorily joining the war reserve. They would be willing to undertake liability for foreign service.

(General Hendley.) The reason why so very few sub-assistant surgeons in the Punjab had volunteered for field service was that the prospects offered to them were not adequate. The assistant surgeon, who got a temporary commission in the Indian Medical Service received a salary of Rs. 450 while in India, and Rs. 540 outside India, whereas a sub-assistant surgeon received only Rs. 140, which included allowances. Pensions, however, were reckoned on the bare salary of Rs. 30 and not on the total emoluments amounting to Rs. 140. Another reason was the question of commissions. The sub-assistant surgeon had to serve as a warrant officer,

and did not receive even the Indian commission of jemadar. It was a combination of these reasons which operated in causing sub-assistant surgeons to hold back. The assistant surgeon had volunteered for field service because he got better terms than the sub-assistant surgeon. Most of the civil assistant surgeons who had volunteered were, however, junior men. Very few of the senior men were to be found among them. They were not willing to sacrifice anything for the sake of the Empire.

(General Hendley.) He could not say definitely whether the sub-assistant surgeon would be prepared to enter Government service, civil and military, through one channel which would be military, like the Indian Medical Service, but he thought it would have a bad effect on recruiting.

(General Hendley.) He was not satisfied with his designation of sub-assistant surgeon, as the name did not convey much. As he had stated in his written statement, he would propose the designations suggested by the Punjab Medical Council, namely, district medical officer for civil surgeon, deputy district medical officer for assistant surgeon, and assistant district medical officer for sub-assistant surgeon. An alternative proposal would be medical officer, 1st, 2nd and 3rd class.

He was in favour of the suggestion to extend the period of the education of sub-assistant surgeons. First he would require that the course of instruction at the medical schools in India should be recognised in the United Kingdom. He would not increase the standard of general education, as he thought the entrance or matriculation course quite sufficient.

(General Giffard.) If there was no bond system Government would obtain the number of men they wanted quite easily. He would propose the abolition of free education, and let pupils pay for their own education as they were doing, for the most part, in the Punjab.

The general or medical education of sub-assistant surgeons was not in any way inferior to that of the present assistant surgeon, and he advocated that the former should receive the same privileges of pay, rank, etc., as the latter.

It would be a satisfactory arrangement, and one which would meet with favour at the hands of Indians, if a corps of commissioned medical officers-with registrable qualifications was formed in India as a branch of the Royal Army Medical Corps. Such a corps, he thought, would work very satisfactorily. He did not think it would be looked down upon.

(General Hehir.) He thought it would prove very beneficial if sub-assistant surgeons on the military side were given a course of physical training throughout their college career.

20 February 1919.]

Major F. NORMAN WHITE.

(The schemes and questions referred to by witnesses are contained in Volume III.)

MAJOR F. NORMAN WHITE, C.I.E., M.D., I.M.S., Sanitary Commissioner with the Government of India, called and examined.

(*President.*) He had been two years in his appointment as Sanitary Commissioner, and including this had 6 years' service in the Director-General's office. His total service amounted to 16 years, 4 years of which were in military employ.

The mortality, in connection with the recent influenza epidemic in India, amounted to 5 millions in British India and one million in Native States, or 6 millions in all.

The existing organization to meet the civil medical needs of the country was hopelessly inadequate. One, however, could not conceive of an organization that could have been sufficiently adequate to deal with an epidemic like the recent one. If there had been a larger organization, they would have earlier information of the places where medical help was urgently needed; but whether anything really appreciable could have been done to reduce the mortality was questionable.

Only an infinitely small proportion of the cases was treated by the medical department of the Imperial Government, chiefly on account of the fact that most of the mortality was in rural areas. The disease, in spite of treatment, was exceptionally fatal among Indians. Even if the medical and health departments were a much more efficient organization than at present but little more could be done than was done if an epidemic of such severity should visit the country again.

Plague in India has caused the death of 10½ millions during the last 21 years. What was needed was an organization for the prevention of disease in rural areas, and a rural health staff. At present there was no organization at all to deal with a subject like this.

He was of opinion that the number of civil medical appointments in the Indian Medical Service was quite inadequate for the civil needs of the country. Personally he viewed with disfavour the divorce of the military medical service from the civil, as a better type of officer would result from the combined service. He would not advocate a purely military medical service. He personally would not have entered such a service. With regard to a purely civil medical service, he cited the Colonial Medical Services, which ten years ago did not attract the same quality of officer as the Indian Medical Service then did. He gained this impression in 1906 when he was at the London School of Tropical Medicine; many of the best men that were studying and had studied there were in the Indian Medical Service. It might not be a fair comparison, as it was possible that the keenest men would go there on leave to study. It was the combined attractions of the civil and military services that had given the Indian Medical Service its popularity. The prospect of civil employ had been the main attraction to candidates for the Indian Medical Service in the past, particularly for the special branches such as research. A considerable proportion of the best officers now entering the Indian Medical Service entered the service on account of the attractive field offered for research.

The same stamp of recruit as has in the past entered the Indian Medical Service would not join a separate civil medical service, even if it offered the same attractions as the present Indian Medical Service in respect to civil employ, for the reason that military rank carried distinct advantages. He believed that it was universally admitted that the military medical officer in civil employ was a better government servant than an officer who had had no military training.

He would be inclined to regard the sanitary service as a branch of the new service. He thought that in order to meet adequately civil needs the civil medical service would have to be provincialised. It would be too large an organization to administer centrally. He hoped that a health board of the Government of India would be formed with a provincial health board.

He agreed that the medical needs of India, on the civil side, would grow so rapidly that it would be impossible

for a single service to cater for them. The appointments of rural health officers and health officers of municipalities would have to be provincialised, and there would have to be a provincial health service. He thought that, it would be quite feasible to establish an Imperial public health service in India for superior posts, such as those of sanitary commissioner, deputy sanitary commissioner, etc. At present the duties of the deputy sanitary commissioner were not important; but in future there would be a great deal more work to be done. They would be chiefly inspecting and investigating officers, whose duties would be of great importance in connection with public health developments. These superior officers could with advantage be borne on a central cadre for the whole of India.

With regard to the suggestion that, either the Indian Medical Service must be considerably enlarged, still holding the superior posts, as at present, or the provinces should set up a separate civil service, to which a considerable number of superior posts should be allotted, he thought that the present position was rather difficult. There were at present Indian Medical Service and non-Indian Medical Service deputy sanitary commissioners, and in special cases it would be difficult to pass over an officer for appointment as sanitary commissioner for the reason that he did not belong to the service. Most of the superior medical appointments in the provinces should, however, be reserved for "Indian Medical Service" officers. But it would not be right to draw a hard and fast rule. If there was an appointment calling for expert knowledge, and there was a candidate possessing such knowledge but not belonging to the military medical service, he did not think any bar should be placed on such candidate for that reason.

He did not think that India was a suitable place for short-time contracts.

(*General Hendley.*) Indians of the provincial sanitary service were at present very dissatisfied with their position. The reason was that health officers did not at present belong to any cadre. They were private servants of municipalities; they were apt to meet with disfavour if they did their duty, on account of the vested interests with which they came into conflict. He thought the only solution of this difficulty was to enroll them on a provincial cadre, where they could be controlled and their interests looked after. It was unlikely that rural bodies would raise any objections to such a service. There might, perhaps, be opposition at first. At present the Imperial or provincial governments subsidise these appointments, and might reasonably claim more control over them. Such control would only be exercised in the interests of public health.

In future, when sufficient training schools are established, such as the schools of tropical medicine and hygiene in Calcutta and Bombay, the possession of a qualification awarded by such institutes would be sufficient for entrance to the Sanitary Department.

With regard to the contention, that officers who had been long in civil employ had not proved satisfactory as military medical administrators in the recent war, he maintained that officers with insufficient military training should not be appointed as Assistant Director, Medical Services; civil sanitary experience in India was very valuable to the army and civil sanitary officers are more useful, by reason of their wide experience, than purely military sanitary officers who have had no civil work.

(*General Hehir.*) He agreed that an Indian Medical Service officer should be eligible for the appointment of Divisional Deputy Assistant Director, Medical Services (Sanitary). The appointment was generally held by men who had spent all their service in military. A little civil sanitary training might be useful to such officers. He saw no justification for such appointments being limited to the Royal Army Medical Corps.

20 February 1919.]

Major F. NORMAN WHITE.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

He did not think there was a sufficient number of medical colleges and schools in India for post-graduate training; but he thought that this would in some measure

be put right by the establishment of the proposed schools of Tropical Medicine.

CAPTAIN J. C. BLAIKIE, R.A.M.C., British Station Hospital, Meerut.

Written statement regarding assistant surgeons.

The rôle now filled in a British station hospital by the military assistant surgeon is necessary to a certain extent. I do not think it practicable to replace him altogether. He could to a certain extent be replaced by a non-professional man. His duties as quartermaster, wardmaster, storekeeper and dispenser could be performed by a non-professional man. His professional duties and duties as resident medical officer could not be so performed. Commissioned medical officers would require to be constantly within call, especially in the hot weather. I do not think that orderly duty as performed at home would be tolerated by British medical officers in India.

I consider that no further recruitment of assistant surgeons, as they are educated at present, should take place. If their education was raised to the standard required to obtain a qualification registrable in the United Kingdom, I would be in favour of continuing to recruit

military assistant surgeons, but it would not be feasible to put them on the same status with commissioned medical officers. In certain cases they should I think be promoted to this status.

If the assistant surgeon were educated as suggested above I would employ him on the professional part of the work in a British station hospital that he does at present, but with considerably more scope and responsibility. His work could be supervised by medical officers who would act as visiting surgeons and physicians and would be shown and consulted about interesting and important cases.

The pay and pension of military assistant surgeons should be substantially increased. Promotion to commissioned rank should be possible in cases of exceptional merit. This might be controlled by recommendation and examination.

CAPTAIN C. J. BLAIKIE, R.A.M.C., called and examined.

(*President.*) He had 7 years' service in the Royal Army Medical Corps, and had been 5 years in India, except for 7 months spent in Mesopotamia.

He was not satisfied with his present rate of pay.

(*General Cree.*) He would resent being commanded by an Indian officer of the proposed auxiliary corps (scheme A). In the event of Royal Army Medical Corps officers being seconded to the Indian Medical Service, he would not care to serve under the command of Indian and Anglo-Indian officers of the Indian Medical Service.

(*General Hehir.*) With reference to scheme C, he would personally prefer to serve as a Royal Army Medical Corps officer seconded to the Indian Medical Service rather than to transfer to that service, as he would be able, in the former case, to return to England for a period, coming out to India again, if necessary.

If the rank and file of the Royal Army Medical Corps were employed in British station hospitals in India, difficulties would arise between the warrant officers of the corps and assistant surgeons (warrant officers) of the Indian Medical Department serving in the same hospital. This might be avoided if their duties were made separate and distinct, the Royal Army Medical Corps warrant officers being responsible for discipline, and the assistant surgeons being restricted to professional duties.

He was not prepared to recommend the abolition of the assistant surgeon, because he fulfilled the rôle of Resident medical officer in British station hospitals, a duty that would otherwise devolve on Royal Army Medical Corps officers.

He was of opinion that assistant surgeons should be allowed a certain amount of professional work in the hospitals. Apart from other considerations, this would tend to greater contentment on their part.

(*General Giffard.*) He disliked the proposals contained in scheme A for the reason that Royal Army Medical Corps officers arriving in India would find that their corps was divided into two portions—one being the auxiliary corps. Under scheme B, again, they would find themselves seconded to serve under another corps—an idea which was not acceptable, especially as some of the officers of this corps would be Indians or Anglo-Indians.

When young medical men are considering what service they should join they really know very little of the conditions prevailing in India. In spite of this, however, he considered that a certain number of well qualified doctors were deterred from joining the Indian Medical Service by the knowledge that some of the officers of that service were Indians.

21 February 1919.]

The Hon'ble Colonel R. C. MacWatt.

(The schemes and questions referred to by witnesses are contained in Volume III.)

At Delhi, Friday, 21st February 1919.

PRESENT :

The Hon'ble Sir Verney Lovett, K.C.S.I., I.C.S. (President).

MAJOR-GENERAL G. CREE, C.B., C.M.G., A.M.S.

MAJOR-GENERAL P. HEHIR, C.B., C.M.G., C.I.E., I.M.S.

MAJOR-GENERAL H. HENDLEY, K.H.S., I.M.S.

THE Hon'ble MAJOR-GENERAL G. G. GIFFARD, C.S.I., I.M.S.

S. R. HIGNELL, Esq., C.I.E., I.C.S.

LT.-COL. A. SHAIRP, C.M.G., INDIAN ARMY.

LT.-COL. G. B. A. RIND, INDIAN ARMY.

MAJOR M. T. CRAMER-ROBERTS, D.S.O., INDIAN ARMY.

MAJOR A. A. MCNEIGHT, I.M.S. (Secretary).

THE Hon'ble COLONEL R. C. MACWATT, C.I.E., I.M.S., Inspector-General of Civil Hospitals, Punjab.

Written statement.

Replies to questions to be asked of service officers.

	Years.	Days.
In military service	8	99
In civil service	22	335
In civil with collateral medical charge of regiments	7	182

so that I have been associated with military medical work for 15 years 281 days out of a total service of 31 years 144 days.

Complaint or discontent.—In common with others, discontent in regard to inadequate pay, delayed promotion, delay in promotion to the selected list, delay in obtaining full pension.

I did not obtain promotion to administrative grade qualifying for extra pension until after 30 years' service and over 53 years of age, so that I should have to serve until over 58 years old if I wished to earn the full pension of a colonel Indian Medical Service. An officer of my batch much below me on the list on passing out of Netley was promoted on 15th May 1914 and will earn full pension of administrative grade (colonel Indian Medical Service) on 14th May 1919. Another Officer on the Madras List $2\frac{1}{2}$ years junior to me was promoted more than two years earlier than myself.

I held the appointment of Chief Medical Officer in Rajputana for 4 years 264 days of which period 1 year was officiating. I consider that service in that appointment or at least the time which was not officiating should qualify for the extra pension of administrative grade: the work was administrative in character—heavier than the appointment of an Assistant Director, Medical Services (e.g., Derajat Brigade), in addition to the heavy charge of civil surgeon, Ajmer: it is, however, ruled, for purposes of pension and promotion, that the appointment was not on the list of administrative appointments. But although I held three visiting medical charges for prolonged periods, for each of which as an executive medical officer I was entitled to visiting charge of Rs. 100 per month, the amounts were disallowed on the ground that I was discharging the duties of more than one appointment in the same office or on the same establishment, viz., of the Chief Medical Officer in Rajputana, analogous with the rule that the Inspector-General, Civil Hospitals, Punjab, cannot draw allowances for holding the appointments temporarily of Chief Plague Medical Officer and Chief Malaria Medical Officer.

I have met with no instances of friction between the Royal Army Medical Corps and Indian Medical Service. My own limited relations with officers of the

Royal Army Medical Corps have always been cordial and frequently friendly.

As grievances or friction are admitted to exist I would suggest that evidence be taken from representative medical officers of Royal Army Medical Corps and of Indian Medical Service in military employment, say, of five, ten, fifteen, twenty-five years' service, respectively, when the causes would be revealed first-hand and measures could no doubt be devised to neutralise grievances or friction.

Personally I consider that if the office of Director, Medical Services in India, were held alternately by officers of the Royal Army Medical Corps and Indian Medical Service, so that the officers of the latter Service would feel that their interests were being protected, it would help to improve relationships. Officers of the Indian Medical Service should have at least the same standing as those of the Royal Army Medical Corps.

(a) I do not see the necessity for fixing any hard and fast rule. If an officer is transferred to civil within the first five years of his service it is no doubt all the better for his future prospects in civil: but there is no reason why if the transfer is delayed even up to ten or twelve years his utility in civil should be impaired. Theoretically the longer time he served in military the more suitable he will be for promotion to military employment in due course.

(b) Nor do I see why any limit should be fixed for transfer from civil to military. Senior medical officers in civil have much organising and administrative work in addition to their medical and surgical duties proper, and, unless they suffer from mental lassitude due to advancing years, prolonged residence in India, or other cause, there is no reason why they should not very soon become conversant with the rules and regulations which govern military medical service.

Replies to questions for witnesses.

I cannot say that I have noticed defects in the organization of the Indian Medical Service, and I am not competent to offer criticism in the case of the Royal Army Medical Corps. As these are said to exist I conclude they are fostered by dual control by the War Office and the Government of India; by the acknowledged friction between Royal Army Medical Corps and Indian Medical Service; and by the progressive unpopularity and discontent in the Indian Medical Service.

Scheme C with certain modifications commends itself to me more than any of the other three, if an unified service for India must be adopted, as it is more likely to meet military as well as civil requirements.

As the civil medical department is seriously undermanned in European commissioned officers more civil

21 February 1919.]

The Hon'ble Colonel R. C. MacWATT.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)—

surgeoncies should be reserved for them. Surgeons-General and Inspectors-General of Civil Hospitals should have European Indian Medical Service officers as deputies or assistants. Civil surgeons of large stations and districts ought to have commissioned Indian Medical Service officers as assistants. There should also be an increase of commissioned medical officers serving under sanitary commissioners. A substantial reserve could thus be built up, available in war time.

Military assistant surgeons should have qualifications registrable in the United Kingdom: their numbers in civil employ should be increased.

The present civil assistant surgeon and sub-assistant surgeon students should be trained as military pupils and passed out of the medical colleges and schools into military service with liability for a period of military duty and drafted into civil appointments as required. They should be available for military duty for, say, twenty years. A large reserve would be formed to draw upon for military requirements in times of need.

Compounders should also be recruited through the military channel and transferred to civil hospitals and dispensaries. They would be liable to be called up in the case of military necessity. While in military they would be infinitely superior to ward orderlies, who, in my experience, are too often mentally obtuse sepoys, handed over from regiments as being incompetent combatants.

The cadres of assistant surgeons and sub-assistant surgeons should undergo a large increase for the staffing of many new district hospitals and dispensaries which are being opened and will be opened in the future.

I consider that the practice of promoting lieutenant-colonels, Indian Medical Service, from the civil side to be administrative officers on the military establishment should continue as at present. Some officers so promoted may have been considered inefficient: but it may be asked if cases of inefficiency have not occurred amongst officers of the Royal Army Medical Corps promoted to administrative rank.

If it is definitely decided that reversion to military from civil for a period of six months after every five years' service in civil, I consider officers so temporarily transferred should retain a lien on their substantive appointments in civil.

I am of opinion that it should be so arranged that medical officers should be in a position to be promoted before they are over 50 years of age. Many of them have friends and relatives in or retired from the army, and there seems no valid reason why they should not quickly regain the military atmosphere, instinct, and touch with troops.

I am altogether opposed to examinations for promotion on professional subjects. If a man has not the self-respect and professional zeal to keep up his medical and surgical knowledge he is not fit for promotion; and this can be elicited from his confidential reports and enquired into by the head of his department.

Nor do I see any use of Promotion Boards. The present system of promotion would appear to work all right: and unless an officer is incompetent his promotion should be a matter of course. As Indian Medical Service officers are now divorced from regiments, there would seem to be no place on such boards for combatant officers: and the assembling of a number of senior Indian Medical Corps officers periodically is to my mind an unjustifiable expenditure of Government money in travelling allowance, and a waste of time of the senior medical officers who would be more profitably employed in looking after their duties in connection with their sick, or their administrative work.

Military assistant surgeons should have the opportunity of taking the same qualifications as the present civil assistant surgeons have.

I consider all sub-assistant surgeons should be military: and the wants of the civil departments should

be supplied from the cadre. In military they should be employed in the recently instituted Indian station hospitals under Indian (civil) assistant surgeons.

The present so-called civil assistant surgeon students who wish Government employment, like the sub-assistant surgeons, should be treated as military pupils and pass out into military service, in the same way as the present Indian Medical Service officer is recruited, and drafted into civil as required. They would be liable to recall to military whenever necessary. They and the sub-assistant surgeons in civil employ would provide a large war reserve. If considered necessary both classes could be called up for a six months' tour of military duty every five years.

Specialists in military employ.—Practically we have specialists in most branches in the ranks of the Indian Medical Service available in and acquainted with the conditions of India. It is a question whether they are not more suitable than specialists imported from time to time from the United Kingdom would be. Those with special qualifications might be encouraged to resort to England or Schools of Tropical Medicine in India, as the case may be, to keep themselves abreast with recent changes or advances.

I think scheme C modified, as I have indicated, will meet the demands of the army in India: I do not see why it should not meet with the approval of the War Office.

I think any scheme is likely to fail to attract a good stamp of recruits until confidence is re-established in the Indian Medical Service and the present discontent removed. What is required is a settled policy so that officers know where they are. The following points require attention:—

- (a) Increase of pay and pension.
- (b) Increase in the number of higher-paid appointments.
- (c) Facility in obtaining leave and furlough when due without resort to sick leave.
- (d) Decrease in length of service for full pension.
- (e) Abolition of the "selected" list. Officers should go on a higher scale of pay automatically after a certain length of service.
- (f) Care in selection of suitable Indians socially and otherwise for admission permanently to the Indian Medical Service. It is to be hoped that those with temporary commissions will not be drafted wholesale into the service. Those accepted should be in no way socially inferior to Indians selected for commissions in the combatant ranks: otherwise the standing of the Indian Medical Service will be still further lowered.

I am averse to any scheme to abolish the Indian Medical Service with its old traditions and its great name in the past, which I think should be rehabilitated and resuscitated.

So far as civil districts are concerned great discontent prevails among the civil officers of districts as regards themselves and their families. Many have had to bring their wives and relatives to stations where European medical officers are stationed or have called European officers to attend members of their families at considerable expense and anxiety as to the welfare of the sick. The Indian civil surgeon has frequently failed to inspire confidence and to diagnose or treat such cases correctly. If this continues it will have a baneful effect in the recruitment of the various civil services. The discipline and medical administration of district hospitals and dispensaries have undergone a general decline: and complaints have been received that medico-legal work has suffered. In jails there has been a considerable increase of tuberculosis and outbreaks of infectious diseases, due to the more slack discipline and less attention to details of cleanliness and sanitation on the part of Indian civil surgeons. The Inspector-General of Jails can endorse this opinion.

21 February 1919.]

The Hon'ble Colonel R. C. MacWATT.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

Scheme C with modifications suggested by me, I consider, would give a sufficient and efficient reserve for military purposes.

Scheme C with modifications suggested by me would give a medical service reserve for war which has undergone previous training in military work, which is desirable. It would always be actually present in India except for absentees on leave and furlough who could be recalled, if necessary.

The Indian Medical Service reserve (civil side) has proved of such inestimable value in the war that I cannot see how military medical arrangements could have been carried on without it. Every province was depleted to the utmost; and the number of honours and rewards and brevet promotions given testifies to the good work done by those who had been on civil duty for long periods.

The present rules for education and recruitment for the Indian Medical Service, by competitive examination in England should be retained.

10. *Special leave for study as at present.*—It should be ensured that an officer can obtain the special leave. It would be hard on men who cannot be spared should they be superseded by those of their own length of service who have obtained study leave and consequent special promotion. For specialists and consultants extra period should be allowed as also for those who wish to take out courses on special subjects.

11. I have no special suggestions to make. I think officers employed on research work would be more likely to make useful and practical suggestions.

12. The evidence of the Director-General, Indian Medical Service, before the Public Services Commission dealt fully with this subject on which I am not competent to express a reliable opinion.

I should say that private practice is in the hands of civil assistant surgeons, sub-assistant surgeons and independent medical practitioners; and Indian Medical Service officers in civil employ do practically only consulting practice. The reason I believe to be the usually smaller fees charged by the above; the Indian Medical Service officer has no desire to compete with them, and besides, with increased efficiency the duties of the Indian Medical Service officer show progressive increase leaving him no spare time for private practice should he wish it. I believe the lucrative private practice of officers in the Indian Medical Service in most cases does not exist.

Special questions.

1. The demands of European members of the public services for European medical attendance on themselves, and incomparably more so on their families, are based very largely on racial predilection: and this will always be the case as long as the religion, ideas, habits and customs, especially in regard to women, differ to the extent they now do. Many European women who really require medical advice and have not the opportunity of consulting an European, go on without it in preference to calling in an Indian doctor; and in cases of maternity or disease peculiar to women Europeans of every class positively refuse to have an Indian doctor to attend them. Europeans consider that Indian medical officers are generally not so careful or sympathetic as Europeans, especially when treating those who are not in authority; that they are usually wanting in self-confidence in the matter of diagnosis and treatment and are apt to follow the dictates of the patients; that they do not understand European methods of living especially as regards home hygiene and diet; that they do not after obtaining their medical qualifications as a rule keep themselves abreast of the times in medical study. European ladies have not the confidence in the Indian that they have in the European, which is an important factor in treatment. The vast majority would prefer the most recently qualified European to the most experienced Indian. Added to which, Indian practitioners

are not practically experienced in the diseases of women and English children.

2. Europeans have not been satisfied with the medical treatment received from Indian substitutes for European medical officers withdrawn from the charge of civil districts; and there are instances where, from facts of which I have been placed in possession, they have had good reason to be dissatisfied. They have met the difficulty by calling in a missionary doctor, a medical officer on military duty in a neighbouring cantonment, or from another station. In other cases patients have been taken to stations at a considerable distance, sometimes when they should not have undergone journeys, for European advice and treatment. Europeans send their wives to nursing homes in Delhi, Lahore and elsewhere for their confinements. This is a great expense and a source of much discomfort, anxiety and discontent: and must have an adverse effect on the recruitment of Europeans for the public services.

3. I cannot answer this question as I have no personal knowledge.

Answers to questions to be asked of officers regarding Assistant Surgeons and Sub-Assistant Surgeons.

1. The form of bond is that prescribed in Government of India, Home Department, letter No. 7-Medical—668-679, dated 12th October 1891. No alteration has been made in it during the war.

If the civil sub-assistant surgeon branch is to be maintained separate from the military the bond should be altered to make it incumbent on a stipend-holder to serve in the sub-assistant surgeons department for a period of five years in either civil or military in any part of the world. No special difficulty has been experienced in enforcing the conditions of the bond. A sub-assistant surgeon who has made up his mind to resign before the termination of the five years pays the penalty described without demur.

2. I think it would be possible to make the bond renewable every five years up to twenty years of service.

3. I do not think the conditions of service altogether satisfactory. The pay is inadequate and should be increased; a fourth grade sub-assistant surgeon draws less pay than an ordinary cook, or than an uneducated man who has picked up the rudimentary mechanics of a motor car and can drive it more or less efficiently. I consider also that the status of the sub-assistant surgeon should be raised say to that of jamadar in the junior and subedar in the senior grades. We might then hope to attract a better class of men who would be expected to maintain a higher degree of professional knowledge and sense of discipline. A levelling up socially also would not be too much to look for.

4. The whole of the present reserve of 15 per cent. of assistant surgeons and half the reserve of 25 per cent. of sub-assistant surgeons. Leave would of course be closed. The number employed could be advantageously increased; and in fact a progressive increase is taking place. Assistant surgeons could be and are being more extensively employed in hospitals and dispensaries which are or have been in charge of sub-assistant surgeons. They could be utilised as district medical inspectors of schools (high, middle and primary), as health officers or assistant health officers of large towns if they had the requisite training and possessed the necessary qualifications in public health, supervisors of district itinerating dispensaries, registrars of large hospitals, etc. In more of the larger hospitals two assistant surgeons might with advantage be employed instead of one. There is a tendency for assistant surgeons to concentrate their energies on operative surgery and relegate the out-door department to sub-assistant surgeons who are too apt to diagnose and treat cases inefficiently. It is common to find a district hospital where the assistant surgeon

21 February 1919.]

The Hon'ble Colonel R. C. MacWatt.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

triumphantly shows a long list of cataract operations: but on inspecting the out-patient department the register shows many cases of "Cough," "Rheumatism," "Fever," "Ascites," etc., which are not diagnosed at all. So that the medical cases fare badly as compared with the surgical. The reserve of assistant surgeons should be increased from 15 to 20 per cent.

Many new district dispensaries are being opened, and it is hoped that many more will be opened in the near future for which the cadre of sub-assistant surgeons will be greatly increased. They can also be advantageously employed in connection with the registration of vital statistics, as sanitary inspectors in towns and districts, rural health officers, medical inspectors of village schools, and in large hospitals and dispensaries as assistants to assistant surgeons. The reserve of sub-assistant surgeons should be increased from 25 to 30 per cent.

No actual dislocation of work resulted from the war though the withdrawal of men threw a very heavy strain on those who remained; and many of the temporary men employed as substitutes were anything but satisfactory. The epidemic of influenza in October and November 1918 caused a certain amount of temporary dislocation in some places on account of the medical department being depleted to the utmost limit compatible with carrying on under normal conditions. Many assistant surgeons and sub-assistant surgeons suffered severely from the disease to which a number succumbed, and the greatest difficulty was experienced in filling their places. The state of affairs was, however, unique and could never have been foreseen.

5. I consider assistant surgeons in Government employment should be trained as military pupils and passed into civil through military, so that, like Indian Medical Service officers, they would always be liable to be called up. If this cannot be done I think it is desirable to require civil assistant surgeons to sign the agreement suggested making them liable for military service up to 20 years.

I must confess, however, that this method in the case of both civil assistant surgeons and sub-assistant surgeons savours somewhat of conscription and if applied to the medical department might be held applicable to members of other civil departments also; training both assistant surgeons and sub-assistant surgeons as military pupils and passing them through the military department to my mind would be much more satisfactory. I doubt if many of the present class of civil assistant surgeons could be induced to sign such an agreement. I believe the majority of civil assistant surgeons volunteered in the present war because they obtained temporary commissions in the Indian Medical Service which most of them hoped to be made permanent. Without this attraction I think only a very few, and those belonging to the martial classes, would have come forward.

They should be available for military service anywhere during their first twenty years of service.

6. No. More Indian Medical Service officers are required in civil, jail, sanitary department, and medical teaching institutions so that more efficient control and supervision could be exercised which would be to the advantage of the people and of the medical staff.

7. The military sub-assistant surgeons would not adequately fill the place of a resident medical officer.

I consider an officer of the qualifications and status of the present civil assistant surgeon is necessary for such a post with sub-assistant surgeons serving under him. In my scheme military sub-assistant surgeons could be drafted to civil duties suitable to their attainments.

8. So far as I have seen his training is such as is required for military purposes, but I think a higher standard of professional knowledge, both theoretical and practical, should be aimed at.

9. I had no opportunity of judging in actual warfare. In military hospitals I should say on the whole the military sub-assistant surgeon was the better man all round. I, however, came across one or two civil sub-assistant surgeons who rapidly mastered regulations governing military hospitals and were better than the average military sub-assistant surgeon in professional efficiency. One 4th grade civil sub-assistant surgeon from Madras very quickly made himself acquainted with military medical work, and in professional efficiency and zeal was one of the best sub-assistant surgeons I have ever come across.

10. Yes. Civil assistant surgeons (or their prototypes if transformed into military) should be employed as resident medical officers with civil (also militarised) sub-assistant surgeons serving under them. They could be utilised as suggested.

11. All new recruits should be primarily military. They should be better paid and expected to maintain a higher standard of professional knowledge as a class. They should receive official status commencing with the rank of jamadar with promotion to subedar.

Their widows and families should receive pensions

12. No reply.

13. In the civil department they were employed when over age for active service and re-employed in fairly large numbers in railway, asylum and jail appointments and as civil surgeons, and acquitted themselves creditably. Through this assistance the Punjab Medical Department was able to surrender far more Indian Medical Service officers than would otherwise have been the case.

14. In civil as civil surgeons of certain districts as at present, also in laboratories, medical colleges and schools, in medical store depots, assistants to civil surgeons, to superintendents of lunatic asylums, Lawrence Military Asylums, as assistants to railway medical officers; and probably in other appointments.

15. So far as civil is concerned they are a very useful body of officers: and it would be unfortunate if they were no longer obtainable.

16. Yes. They satisfy the test laid down for admission to Government medical colleges. The demand for better education has been realised by them, and candidates should be available for scholarships. Their professional training is in no way inferior to that of Indian graduates than whom they are generally more successful in organisation, discipline and administration. They should be eligible for the M. B. B. S. degrees of Lahore and other medical colleges which are registrable in the United Kingdom.

17. So far as civil is concerned, as in answer to question 14.

18. I believe valuable suggestions could be obtained from some of the senior and experienced officers of the military assistant surgeon class.

COLONEL R. C. MacWatt, called and examined.

(President.) He was not in favour of scheme A as he did not think recruits could be obtained for such a service. The proposed auxiliary corps would in reality be a subordinate service, and Indians would not be willing to join it. Another objection was that European officers who transferred to the Royal Army Medical Corps would feel that they were interlopers, and might not receive the same treatment as officers who originally entered that corps.

A separate medical civil service would do away with the prospect of getting officers for the war reserve. This would necessitate conscription in time of emergency. Indian civil surgeons would not give up their appointments in the event of war, as their emoluments greatly increased when regular officers were withdrawn for military duty. The reason that Indian civil assistant surgeons volunteered for military service during the late war was because they received temporary commissions

21 February 1919.]

The Hon'ble Colonel R. C. MacWatt.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

in the Indian Medical Service and hoped that they would be permanently retained as commissioned officers. If they had to enter a service unassociated with military status, he did not think they would volunteer.

He would enlarge the total cadre of the medical service so that not only would the officers forming the war reserve be available for civil duties in peace time, but there would in addition be a considerable number of officers in civil employ in excess of the requirements of the war reserve. In other words, he would base the total cadre on the military requirements (both for peace and war) *plus* a sufficient number to provide those needed for civil duties. He was not in favour of a unified service, but would perpetuate the present system with a large increase in the cadre of Indian Medical Service officers.

All members of the civil medical service, including assistant and sub-assistant surgeons and compounders, as well as officers, should first enter the military side of the service and then pass to civil, as required, retaining a liability to be called out for military duty in time of war.

The increase in the cadre which he proposed would allow of the opening up of a large number of additional civil dispensaries, many of which could be closed in the event of war.

With regard to the complaint that Indian Medical Service officers recalled from civil employ had not proved satisfactory military medical administrators during the late war, he thought that if an officer was taken right away from civil to do duty in military, it was rather unfair to expect him to fill an administrative post successfully. He should be put in an administrative charge in India before being sent on active service.

With regard to meeting the difficulty of the racial preference of Europeans for European medical attendance on themselves and their families, he thought there should be a European medical officer available in every district and cantonment, or at least within reach of every district, for attendance on Europeans and their wives and families. He thought this was necessary if they wanted to recruit all the public services satisfactorily and keep them up to a high standard.

(General Cree.) He did not think that the desire on the part of European officials and their wives and families for European medical attendance could be met by the institution of hospitals for them, such as maternity hospitals and children's hospitals, somewhat on the lines that existed in military cantonments, as that was one of the great causes of complaint among civil officials, on account of the expense it entailed. Even if the question of expense was met, he thought it was also a matter of sentiment as many people objected to having to send their families to hospital when ill.

(General Hehir.) He thought that if scheme C were modified, as suggested in his written statement, it would meet the case. He would advocate the continuance of the present system with the improvements he had suggested.

There were grave objections to the suggestion to pool the whole of the Royal Army Medical Corps and Indian Medical Service in military employ, and not to limit Royal Army Medical Corps officers to the care of British troops. Unless the Royal Army Medical Corps officer had spent a good deal of his time in India, he would be very much at a disadvantage in the treatment of Indians owing to his lack of knowledge of their languages and customs.

The prospect of the independent medical profession in the provinces forming part of the war reserve was very small, so far as the Punjab was concerned. Indian medical men in the Punjab who enjoyed a lucrative practice, had a most profitable time when men were called up for the reserve. The only men the army had obtained were waifs and strays of the medical profession, who were eking out a precarious existence, and these would be the only men they would be likely to get.

If it were decided to largely increase the cadre of Indian Medical Service officers the Punjab Government would gladly take a larger number of them than at present into civil employ.

He thought that if the reputed causes of discontent in the Indian Medical Service were removed, and a definite policy was indicated, the Indian Medical Service may regain some of its old popularity; but he would not like to say definitely that the same class of men as entered the service previously would join it in future.

He did not think that independent Indian practitioners of the provinces were capable of holding superior appointments in the provinces with the same degree of efficiency as the Indian Medical Service officers. The medical teaching in all the schools would be better done by Indian Medical Service officers than by independent practitioners.

The periodical transfer of Indian Medical Service officers from military to civil would raise the standard of treatment in military hospitals, as the latter would benefit by the officers' civil medical experience.

Nursing in Indian station hospitals by ward orderlies was far from satisfactory. In his scheme the civil compounder would be put through a military training and transferred to military service.

He considered the idea of having nursing sisters, with subordinate nurses under them, as obtained in the large civil hospitals, a very experimental one, and doubted its advisability, so long as Indian and English ideas in regard to women existed. There would have to be the proviso that the supervision should be very strict, as was the case in the hospital at Lahore, where such a system was found to work satisfactorily.

He had no personal experience of friction between Royal Army Medical Corps and Indian Medical Services. But one of the chief causes of such friction was undoubtedly the fact that the Director, Medical Services in India, was always an officer of the British service. The feeling prevailed that, under these circumstances, the interests of Indian Medical Service officers suffered.

(General Hendley.) He had no cause of complaint with regard to the methods employed by the Medical Stores Department in supplying stores for the Government medical institutions in the Punjab. With regard to local fund dispensaries having the right to obtain their stocks from medical depôts, some might accept this system and some might not, so that the advantage of such a scheme would be problematical. If local bodies were compelled to get their supplies from medical depôts, he thought it would be rather unfair, as they might get them cheaper elsewhere. If they were asked and agreed, they would have to enter into an agreement for a certain number of years, say, 3. The question as to whether local bodies would do this depended largely on the prices charged by the Medical Store Department, and on the advice they received from civil surgeons and the Inspectors-General, Civil Hospitals.

(Mr. Hignell.) He was a Member of the Punjab Legislative Council, but did not remember that any discussion had taken place in that Council on the future organisation of the medical services in India. He was not aware of a similar discussion in the Imperial and United Provinces Legislative Councils. If the question had been discussed, and a unanimous vote of Indians in both Councils in favour of two separate services had been given, he would attach political importance to such a vote as an index to the desire of Indians.

The difficulty with regard to the lack of European medical officers to attend on European officials and their families, had existed for some years, and had been greatly accentuated during the late war when, out of 32 Indian Medical Service officers serving in the Punjab, all but 7 had been recalled to military duty. This difficulty had generally been met by European officials taking their wives and families away for medical

21 February 1919.]

The Hon'ble Colonel R. C. MacWATT.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

treatment at other stations, or by going to the expense of sending for a European medical officer from another station. He did not think the difficulty would be met by Government undertaking the cost of sending a European expert to remote stations where there were Indian civil surgeons in charge. It would be necessary to employ European officers in all the big stations.

He would limit the number of Indians in the Indian Medical Service to at most 25 per cent. of the total cadre.

He did not think the present reserve of the Indian Medical Service was at all adequate. There had always been trouble in regard to leave, on account of shortage of officers. If there was a larger reserve it would enable

an officer to go home on study leave, and so increase the prospects of recruiting.

He did not think that the idea of an Imperial Indian civil medical service would be favoured by medical students at Home, because the position of the Indian Medical Service officer in civil employ was largely dependent on his military rank.

He did not approve of promotion examinations except for military officers.

He favoured the introduction of compulsory "Study duty" as opposed to "study leave" in order to ensure that officers went to Europe for post-graduate study.

LIEUTENANT-COLONEL D. W. SUTHERLAND, C.I.E., I.M.S., Principal and Professor of Medicine, King Edward Medical College, Lahore.

Written statement.

Replies to questions asked of service officers.

1. I was in military service three years, and have been in civil 22½ years. My total service is 24½ years. Particulars of service—

Date of commission—28th July 1894.

Arrived in India—18th October 1894.

In military from 18th October 1894 to 12th October 1897.

In civil from 13th October 1897 to date—

Professor of Pathology—13th October 1897 to 3rd April 1903.

Professor of Medicine—4th April 1903 to date.

Officiating Principal—10th March 1908 to 13th June 1909.

Principal, Medical College—14th June 1909 to date.

2. *Re complaint or discontent—*

(a) I share in the general discontent of the service about inadequate pay, delayed promotion, delay in obtaining full pension, etc.

(b) In my own particular appointment I am over-worked and—considering my various responsibilities—underpaid.

(c) Men of my batch junior to me, on the Bombay and Madras strengths, are already on the selected list, but with 30 Bengal men still ahead of me on the list of lieutenant-colonels I have no chance of getting on the selected list for years to come.

(d) Along with the other batches from 1890 to 1900 I count service only from the day of leaving Netley, whereas all batches before and after those dates count service from the time of passing the entrance examination.

3. I have had little association with the Royal Army Medical Corps throughout my service, and have, personally, not met with any instances of friction between the two services.

4. I think the proposals outlined in scheme C would do away with friction by amalgamating the two services into one, so far as India is concerned. I am of opinion, however, that discontent will still remain if Royal Army Medical Corps men of a particular date when they enter the Indian Medical Corps are to be counted as senior to Indian Medical Service men of the same date. I think the place of a Royal Army Medical Corps man on the Indian Medical Corps roster should be decided by his combined marks at the entrance and Netley (or Millbank) examinations.

5. (a) I think transfer from military to civil should take place in a young officer's service as early as possible, and before five years at the latest. It is an advantage to the provincial governments to have their young Indian Medical Service officers keen, and full of professional knowledge.

All Indian Medical Corps officers on the completion of 5 years in civil should be obliged to decide whether they are to remain permanently in civil or military.

(b) With regard to the limit of time for reversion from civil to military I am of opinion that no Indian Medical Corps man should be allowed to revert from civil to military after reaching the rank of lieutenant-colonel.

Replies to questions for witnesses.

1. To my mind the chief defects in the present system are:—the presence of two separate medical services in India, the dual control by the War Office and the Government of India, the separate British and Indian station hospitals, the recurring friction between the two services, and the increasing discontent in the Indian Medical Service.

Of the four schemes proposed I think scheme C is the one which would do most to remedy existing defects; for in my opinion it is the most comprehensive scheme of the four, and would meet all military needs, and be the one which would most fully meet all civil requirements.

2. So far as I can judge there is no reason why scheme C should not meet with the approval of the War Office and meet the needs of the army in India.

3. I do not consider any scheme will attract a good class of recruits or meet the demands of professional opinion in England and in India until the present discontent of the existing Indian Medical Service in regard to pay and conditions of service have been remedied. The chief grievances at present are:—

Need for 33½ per cent. increase of pay.

Scarcity of administrative appointments.

Difficulty in obtaining furlough and study leave.

Delay in reaching full pension.

Delay in reaching the selected list.

Loss of service while at Netley, etc.

The criticisms I have to offer in regard to scheme C are the following:—

(a) *Re* paragraphs 1(a) and 18—After the initial permanent transfer of Royal Indian Medical Corps men to start the new service I think the yearly permanent transfers should be strictly limited; for, if unlimited, there may be few vacancies for Europeans and Indians to fill by examination competition.

(b) Paragraphs 1(d) and 24 are not quite clear. Their meaning may be either restriction of civil employ to periods of five years with reversion then to military for the next five years; or civil employ broken by periods of six months military training at the end of each five years. If the latter is what is implied with that I am in complete accord, but if the former is meant I think the plan of continuous civil service with short temporary breaks for maintaining familiarity with military needs is preferable.

21 February 1919.]

Lieutenant-Colonel D. W. SUTHERLAND.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

Five-year tours of duty in civil may do for small civil surgeoncies, and, perhaps, for sanitary and bacteriological appointments, but will be unsuitable for professorships in colleges for a man will lose his chair and revert just at the time when he is becoming most valuable. For important civil surgeoncies limitation to five years will also be prejudicial to the interests of the civil Government and to the general public inasmuch as it usually takes some years for a civil surgeon to gain the confidence of the people and to attract patients in any number to his hospital.

(c) Paragraph 18 as it stands is detrimental to the interests of Indian candidates. Under present regulations Indians with local university degrees—all of which are registrable in the United Kingdom—are eligible to sit in the London examinations, and it would be unfair to compel them to take a British qualification before allowing them to become candidates in the future. At present their only deficiency is that they have an insufficient knowledge of practical midwifery, but that defect could be readily overcome by obliging them to take out a practical midwifery course at some large obstetric hospital in the United Kingdom before appearing for the service examination. Any social defects could be remedied by a course at the Indian Medical Corps Staff College after passing into the service.

(d) An Indian Medical Corps College (para. 40) is part of the scheme, and is to be situated in India, but it is not indicated in the scheme that a course at the Indian Medical Corps College will be necessary for all new officers recruited in England. I think all officers entering the service by competitive examination should go through a six months' course of training at the Indian Medical Corps College and School of Tropical Medicine immediately on reaching India.

(e) I am not in favour of introducing examinations for promotion, and am of opinion that an officer's fitness for promotion can be judged by his work year to year and by the head of the service from the information in his possession.

(f) Promotion boards (para. 27) are perhaps advisable, but I hardly see how they can have personal knowledge of all the men in the service.

4. I have no personal knowledge on this point.

5. I think scheme C will meet the needs of the civil administration. If lieutenant-colonels and men in indispensable civil posts are not to be on the war reserve, and are to remain in civil in war time, I think even a large war will not seriously affect the efficiency of the civil medical departments.

6. I think scheme C with its larger proportion of men in civil will give a sufficient and efficient war reserve, but am not certain on this point for private practitioners are few, and civil assistant surgeons have been spoiled through being invited to ask for permanent commissions, and civil sub-assistant surgeons are not keen on volunteering for military duty without a commission of some kind. A home reserve is one way out of the difficulty, and in times of grave national emergency no post in civil should be considered "indispensable," and lieutenant-colonels should also be taken.

7. I think it advisable that the medical reserve for war should be previously trained in military work, but I believe the requisite training is arranged for in scheme C. So long as most of the war reserve is present in India part of it may be a home reserve in the United Kingdom or in the Dominions.

8. I have no special knowledge to give an opinion on this point.

9. I recommend recruitment by competitive examination in the United Kingdom, and a registrable qualification—with, for Indians, an additional practical midwifery course in the United Kingdom.

10. I think the present rules regarding study leave are suitable, provided arrangements are made for an officer to obtain the leave when required. Over and beyond study leave a period of leave "on deputation" for special educational training or for special laboratory training, or for special work should be procurable in exceptional circumstances, if required.

11. The special department for research should include all branches of medical science—clinical pathology, clinical chemistry, pharmacology, etc.—in addition to sanitary science.

12. It is a well-known fact that private practice has declined in the case of Indian Medical Service officers in civil employ, and exact figures were given by the Director General, Indian Medical Service, in his evidence before the Public Services Commission. The chief reasons for it are: the present high grade training of Indian graduates, the "Swadeshi" tendency which has grown in recent years for Indian practitioners to have Indian consultants in place of Europeans, and the overworking of civil medical officers officially leaving them little leisure for private practice.

Replies to special questions.

1. Racial predilection most certainly plays a great part in the matter, and European members of the public services feel very strongly the present lack of European doctors to give advice to themselves, their wives, and their families. So far as men are concerned they perhaps do not mind very much, but they have great concern for their women-folk and their children, while their wives resent the present state of affairs very deeply. Both European men and women view the future with grave anxiety in this respect, for they fear that matters may become worse still. Also, rightly or wrongly, they regard men of their own race, with European training, as being the better doctors.

2. I have no knowledge as to how Indian substitutes for European Medical officers have affected men in military, but it is common knowledge that officers in military employ have sent their wives during the war to the large civil stations and to the few remaining specialists in civil to get European treatment. In civil the same thing has happened, and many civilians of various classes have come to me for treatment for themselves or their wives, and have complained that their "civil surgeon was hopeless." Several instances have also come to my notice during the war where civil officers have died through the Indian civil surgeon being too careless to make a proper diagnosis of the serious illness from which they were suffering. The difficulty has only been in any way met by the persons affected going to the large military and civil stations to get what they considered proper advice from European doctors or specialists.

3. I have no personal knowledge as to the efficiency of Indian medical officers of the Indian Medical Service in military or civil. One uncovenanted Indian has been on the staff of the Lahore Medical College for over 30 years, and has done good work, comparable in every way with that of a European professor. He has, however, British qualifications, and had some years of medical training in England. Two civil assistant surgeons were temporarily appointed to the Medical College staff during the war to fill the places of European Indian Medical Service officers who had reverted to military duty. Both of them were specially selected and specially qualified men, who had been filling similar teaching appointments in the Lahore Medical School for many years, and if they had not been available no other civil assistant surgeons could have taken their places. Both of them did excellent work, and worthily

21 February 1919.]

Lieutenant-Colonel D. W. SUTHERLAND.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

filled the places of the Indian Medical Service men, but one of them—where out-of-the-ordinary surgical operations were concerned—could not compare with his Indian Medical Service predecessor.

Three military assistant surgeons from the hospital staff reverted to military duty during the war. They had held the posts of Superintendent of the hospital dispensary, Superintendent X-Ray and electrical department, and House Surgeon, Albert Victor Hospital, respectively, and their places were taken by civil assistant surgeons. In each post there was a succession of civil assistant surgeons, and with the exception—the civil assistant surgeon who first took over charge of the dispensary—none of them could compare in efficiency with the former military assistant surgeons.

With regard to young Indian civil assistant surgeons who become house physicians and house surgeons in the Mayo Hospital, some of them during their year's training become most efficient and leave nothing to be desired; some, however, have proved unsatisfactory and have had to be transferred to ordinary provincial work.

I have no direct knowledge of the efficiency of Indian civil assistant surgeons in provincial life; but, judging by their clinical knowledge as shewn in the various grade promotion examinations I should say few of them keep up their knowledge of medicine, and that operative work means more to them than ordinary medical practice.

Speaking of Indians in the medical services as a whole I should say that they have improved in efficiency in recent years, and for some of them who have been good house surgeons and house physicians I have nothing but the highest praise.

Replies to questions regarding assistant surgeons and sub-assistant surgeons.

1. I am of opinion that all assistant surgeons and sub-assistant surgeons entering Government service should be obliged to sign the Indian Subordinate Medical Department bond.

2. If a place can be found in military for the Indian assistant surgeon, as well as for the sub-assistant surgeon I think the bond should be made to hold good up to 15 or 20 years' service, or up to the age of 40.

3. The present conditions of service are not satisfactory—particularly in the case of sub-assistant surgeons. They require much more pay, and also change of designation to jamadars, subadars, etc.

4. I have no personal knowledge of the extent to which the province could supply assistant surgeons and sub-assistant surgeons for military needs without dislocation of the provincial services.

The number of both classes employed could be increased with advantage. The output of assistant surgeons and sub-assistant surgeons in the Punjab will be increased when the Medical School is separated from the Medical College in the near future. Increased employment can be effected by taking more of each class into the medical and sanitary provincial departments, and by encouraging graduates to become private practitioners in villages and small towns by the grant to them of a "parochial allowance."

I believe dislocation has occurred in the provincial medical services during the war, but I have no personal knowledge on this point.

5. I think it is desirable to make civil assistant surgeons sign an agreement to serve in the military department in case of necessity, and I would suggest that the period be up to 20 years' service or 40 years of age.

6. I do not consider the ordinary medical requirements of the State or the general public are met by present

arrangements. More European Indian Medical Service men are required in civil, in the sanitary and jail departments, and in medical colleges and medical schools; and more assistant surgeons and sub-assistant surgeons in the same departments. Control by selected Indian Medical Service officers at the head of each department is essential, and the Provincial Medical Councils should be able to maintain a proper standard of professional rectitude.

7. I have no knowledge on the points raised.

8. I am unable to offer an opinion on this question.

9. I have no special knowledge in regard to the individual points raised. I should, however, like to say a few words in favour of the military assistant surgeon as I have met with him. For over 20 years I have been in touch with military assistant surgeons in civil by having them on the staff of the Mayo Hospital, and have been greatly impressed with their professional knowledge—while most of the men who have served under me are now civil surgeons of repute in the Punjab. They have compared more than favourably with civil assistant surgeons, and during the war when civil assistant surgeons have filled their posts the civil assistant surgeons have not made such efficient medical officers.

I think they suffer injustice by not receiving a diploma which is registrable in the United Kingdom, and they have suffered a distinct hardship during the war by not being eligible for temporary commissions in the Indian Medical Service—especially when civil assistant surgeons have received temporary commissions in such large numbers.

I do not see why members of the domiciled European and Anglo-Indian communities should not receive scholarships from Government, and receive university education for the M.B., B.S. degree, in the same manner that Indians do, and only enter military service after qualifying. The cost of these scholarships should be borne by provincial governments in the same manner as scholarships for Indians, and the annual sum thereby saved by the Army Department would enable that department to give better pay and improved conditions of service to military assistant surgeons while they are on military duty.

With regard to sub-assistant surgeons I think their service should be primarily a military service, and run on the same lines as the present Indian Medical Service. I doubt if it is necessary to pay them stipends from the Army Department while they are at the medical schools, or, at most, "merit" scholarships provided by the provincial governments should be competed for each year—as in the case of assistant surgeon students—and before entrance into the provincial medical services they should complete five years' service in military. If practicable, they should each revert to military for six months at the end of every five years in civil, so as to be able to keep fresh their knowledge of military work. The money saved by the Army Department in stipends, books, and uniform, could be utilised in enhancing their pay and conditions of service. They should be given commissioned rank—commencing as jamadars—and should retain that rank while in civil employ, in the way that Indian Medical Service men do.

I have no knowledge whether a place can be found in military for civil assistant surgeons or not, and if found whether a suitable commissioned rank could be given. But, if so, I would suggest that the service of assistant surgeons be primarily a military service, and run on the same lines as the sub-assistant surgeon service and the Indian Medical Service. The anomaly, however, of having two subordinate military medical services may create a difficulty, but that can be done away with by abolishing the class of sub-assistant surgeons altogether.

LIEUTENANT-COLONEL D. W. SUTHERLAND, called and examined.

(President.) He was the Principal and Professor of Medicine in the King Edward Medical College, Lahore.

He had been in military service for three years and in civil for 22½ years.

21 February 1919.]

Lieutenant-Colonel D. W. SUTHERLAND.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

There was a general discontent in the service as to the inadequacy of the pay which he hoped would soon be remedied.

Transfer from military to civil should take place early in a man's service.

Scheme C was the best. He did not on the whole like scheme A but was unable to offer any detailed criticism.

There should be a unified medical service to look after the whole medical needs of India including those of the British troops. No doubt it would be a very large service but he thought it would be a practicable one and there would not be difficulty in working it. This should be recruited on the same lines as the present Indian Medical Service. He would like Indians to compete for it to the fullest extent by an examination in England except in so far as explained in his written statement.

There were 320 students in the King Edward Medical College and 320 in the school. There were 280 Hindus, 48 Muhammadans and 59 Sikhs. The students belonged to all the castes. A good number of them were the sons of sub-assistant surgeons, a large number were sons of merchants and some were the sons of Indian Army officers.

The students joining the medical college after having passed the Matriculation examination and having thereafter undergone a two years' course in science, that is after having passed the F. Sc. examination of the Punjab University. Their standard of education was deficient in some ways especially in their knowledge of English composition but they made a considerable improvement during their course in the medical college and were quite up to the mark when they left it. They were capable of following the courses of study in the college satisfactorily.

The college course was one of five years or that of seven years taking into consideration the two years devoted to the study of science, and the Medical school course was one of four years. The discipline among the students was good and they gave very little trouble. There had, however, been two strikes, one in 1914 among the students of the military sub-assistant surgeon class who did not want to go to the war, and the second was due to a false report about the proceedings of a meeting held at a medical college in England. The students wanted to hold a protest meeting and not being allowed to do so went on strike. Political agitation was mainly responsible for this strike. On the whole, however, the students behaved very well.

There were 8 full time and 8 part time European professors and one Indian professor so that the college was almost entirely run by European professors.

Before the war students generally looked to becoming assistant surgeons, some of them aspiring to compete for the Indian Medical Service but since the war every one was desirous of getting a commission and all of them looked to joining the Indian Medical Service if they possibly could in the near future. There was general tendency among the Indian students towards the Indian Medical Service and their number in the service would go on increasing.

Wives and families of European officers would not like to be attended by the Indian Medical Service officers. He hoped that this demand would be met by the larger number of Europeans who would be attracted to the Indian Medical Service under scheme C which would consequently bring more Europeans to the civil side. He anticipated no difficulty in getting a larger number of Europeans in this service. The number of Europeans in the Indian Medical Service was decreasing, but if the 33½ per cent. increase of pay recommended by him were granted that would remove one of the great grievances and help to draw men to the service. The other causes which had contributed to bring about the decrease were the scarcity of administrative appointments, difficulty in obtaining study leave and furlough, the delay in getting full pension, etc., as stated in his written statement.

(General Giffard.) He did not think that Europeans would come into the Imperial civil medical

service recommended by the Public Services Commission which would provide mixed careers for the students who would go in for the Royal Army Medical Corps and the Indian Medical Service and which would presumably be recruited at Home. A purely Indian civil medical service would become largely Indianised.

(Mr. Hignell.) Even if the pay, prospects of promotion, leave rules, etc., were improved it would not induce any large number of Europeans to join a civil medical service. One of the greatest attractions to qualified men in making a selection and one which played a very important part was the prospect of military rank and the possibility of reversion to military duty if one got dissatisfied with the civil medical department. Besides this would affect the independence of service and would be subordinate to the Indians.

- He favoured scheme C and thought that it would be desirable to lay down the percentage of Indians who should be admitted to the unified medical service and considered that 33 per cent. would be the proper limit to fix.

As the Principal of the Lahore Medical College he had great opportunities of coming in contact with representative Indians, but he had not discussed this matter with them and could not say what their attitude was.

(General Hendley.) In suggesting the proportion of Indians to be 33 per cent. he had taken into consideration the number of Indians already provided for in the civil services in the Punjab. The percentage was suggested taking the thing as a whole.

He was of opinion that civil assistant surgeons should also be made capable of meeting military requirements and that some military training should be given to them which would teach them discipline for hospital purposes and would make them good residential medical officers. Their service should be primarily military and they should put in five years in the military before they got to the civil side.

With regard to the question whether in view of what happened in this war it would be easy to get a reserve from private practitioners or senior assistant surgeons he pointed out that there were practically no private practitioners in the Punjab except those assistant surgeons who had retired from Government service and had started practice or those who had no qualifications at all. Nor did he think experienced assistant surgeons after having put in 25 years would like to apply for commissions. Very few experienced persons volunteered for field service in the Punjab.

He objected to the idea that medical students at college should be selected after three years and be given scholarships and sent to England to compete for the Indian Medical Service as it was very hard that they should have entered for a degree in one university here and then take a course of another qualification in England which tended to prolong the period of study.

He obtained large quantities of stores from the Medical Store Depot for the college but had no adverse criticism to make as to the methods adopted by the depot. On the whole the department worked satisfactorily and supplied articles with great despatch.

There would be no difficulty if all goods and drugs were supplied by the Medical Store Depot but so far as the chemicals were concerned the depot did not keep a sufficient stock to meet the requirements of the hospital.

(General Hehir.) He was satisfied with the present arrangements for the recruitment of professors. The independent medical profession as it existed at present was not capable of carrying on the educational needs of the country up to the standard required.

With reference to the remark that the medical students in India could not get a complete medical education in this country and that it was specially deficient in particular departments, such as throat diseases, infectious diseases, etc., he suggested that special arrangements could be made for the purpose by attaching special hospitals for these diseases to the colleges. As far as Lahore was concerned the only marked deficiency was

21 February 1919.]

Lieutenant-Colonel D. W. SUTHERLAND.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

in the practical knowledge of midwifery and the diseases of women, and if war had not happened arrangements were in progress to establish a special women's hospital and that was the greatest need. That was the one great deficiency which needed to be provided for first of all. So far as fevers and other infectious diseases were concerned the deficiency could be met by the establishment of special hospitals for the purpose.

He did not think that the laying down of a condition that all civil assistant and sub-assistant surgeons broke down in the field more than any body else was due to want of physical culture. To meet this he explained that for some time past all the military pupils in the Lahore Medical College have had to do infantry drill in addition to the ordinary exercise and for the last two years all the civil students also have had to do drill as well as to take exercise. Since last year the Punjab University had refused to admit students to the university examinations who did not take battalion drill.

The sub-assistant surgeons were fit to be awarded commissions as soon as they came out of the college.

The amount of disciplinary training that they received was quite sufficient for this purpose. This was one of the greatest attractions to the sub-assistant surgeons and they attached more importance to it than even to the question of pay. They felt a great grievance that while civil assistant surgeons were granted commissions they themselves were simply designated as military sub-assistant surgeons which they utterly disliked. If it was not desirable to grant them permanent commissions at once they might be granted temporary commissions and made temporary jamadars, subedars, etc., and be given permanent full commissions after some time when they had completed the necessary military training. This would be a very great attraction to the men and would have a very good effect on recruitment for this class of medical men.

He was in favour of the conversion of the Indian Medical Service into an Indian Medical Corps as outlined in scheme 'C' and to the incorporation as part of the corps of all the members of the present Indian Medical Department,

with the future Indian Hospital Corps forming its rank and file. There would be no great difficulty if a man were brought away from civil to the military for five years. He preferred the system of reversion to military service for a short time to keep in touch with military needs.

There should be certain number of indispensable appointments on the civil side from which officers would not be withdrawn except in a case of extreme urgency. In this category should be included the appointments of professors of colleges and schools. Their training in the military should not be allowed to interfere with their civil duties. The dual control over the medical services by the War Office and the Government of India was detrimental to efficiency.

He recommended that pensions for the Indian Medical Service officers should be brought on the same level as for the Indian Army officers.

General Cree explained with reference to the following remark in paragraph 4 of the witness's written statement. "I think the place of a Royal Army Medical Corps officer on the Indian Medical Corps roster should be decided by his combined marks at the entrance and Netley (or Millbank) examinations" is not possible as the two examinations are quite different and even the total number of marks for the Indian Medical Service and the Royal Army Medical Corps were different. The two were thus not at all comparable.

He also explained that the particular grievance referred to in paragraph 3 of the written statement as to loss of service while at Netley, etc., applied also to the Royal Army Medical Corps.

With reference to the statement in paragraph 3(e) regarding examinations by promotions General Cree explained that Royal Army Medical Corps officers were not promoted by examinations alone and that it was distinctly laid down that these examinations were only intended to show that an officer had undergone a certain course of instruction.

CAPTAIN H. STOTT, O.B.E., I.M.S., Indian Station Hospital, Bannu.

Written statement.

1. How long have you been in military service and how long in civil service?

In military service . . . 8½ years

In civil service . . . 1 year 10 months

with 6 months additional collateral civil charges as civil surgeon, Bannu and Agency surgeon, Tochi.

2. Have you any substantial cause for complaint or discontent?

I have; and since they are service questions as much as personal questions, I now place them before you on behalf of many officers of my service unable to be present here to speak for themselves.

I dislike *intensely* discussing personal topics, but I do so in the hope of some constructive good arising therefrom.

Having been asked for my opinion I give it without reservation, to help you, Sir, in any way it may.

Firstly a substantial cause for complaint as regards leave.

A servant of Government has a moral *right* to expect reasonable leave whereby to maintain his health, to enjoy leisure, and to renew his professional accomplishments.

In the Indian Medical Service this elementary *right* has been to a large extent denied, and denied in an increasingly severe degree.

The leave hardship has fallen with an especially heavy hand on junior majors and on senior captains.

I will illustrate this cause for complaint as regards leave by quoting the *total service* of (and total leave enjoyed by) the permanent Indian Medical Service

officers attached to the last two medical units with which I have had the honour to serve during the past 5 years.

It is apparent that these units are in no way selected to shew officers with prolonged service and with only short leave, but they represent the *chance* Indian Medical Service units to which I have been accredited.

Firstly, then, concerning the Bannu Brigade, in which I am at present serving. Excluding the administrative head, I append the names of the six Indian Medical Service officers with whom I have worked during the past 9 months, together with their total service, and the total amount of leave, out of India, which they have enjoyed. The statement includes leave of every description, whether furlough, sick leave, study leave, or leave on urgent private affairs.

Officers.	Years service.	Years leave enjoyed.
Major Shettle	14½	½
Major Hume	13	..
Captain Stott	10½	..
Captain Smith	9½	..
Captain Murphy	8½	..
Captain Unger	4	..
TOTAL	60	½

21 February 1919.]

Captain H. STOTT.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

The service of these officers totals in all 60 years. The total amount of leave of every description, out of India, enjoyed by them reaches 6 months. That is an average of *one month's leave in each 10 years of service.*

Secondly, in my previous appointment on the Hospital Ship 'Madras' excluding the administrative head there were three permanent officers of the Indian Medical Service. I append their names, their service and the furlough they have enjoyed.

Officers.	Years service.	Years leave.
Bt. Major Wright	11½	..
Captain Fraser	12½	½
Captain Stott	10½	..
TOTAL	35	½ (Sick.)

The service of these three officers totals 35 years. The total amount of leave of all description out of India they have enjoyed is 6 months, and that only obtained by the order of a medical board.

Taking, then, these two chance units together, the total years' service of the officers composing them is 95 years. Whilst the total amount of leave enjoyed, excluding only the 6 months ordered by a medical board, is *one half year.* That is, 6 months in 95 years' service. 95 years' service with only 6 months' leave. It will be noticed that in 95 years' service no officer has in any case ever obtained study leave.

In all seriousness, Sir, I will not trust myself to comment on these facts.

3. As regards myself, with a total service of 10½ years, I have never yet been able to obtain furlough. At the present time, estimating at the usual civil rate of a quarter of one's service, I have about 2½ years' furlough due, in addition to 10 months' study and 3 months' privilege leave or approximately a total of 3½ years' leave due. At the present moment my prospects of obtaining leave rest in the intervention of Providence in the shape of a severe or fatal illness.

On two occasions, whilst in Burma, when I had some 5 years' total service, I wrote to my Assistant Director, Medical Services, asking for furlough and study leave and in each case was asked to carry on with the research and malarial work on which I was then engaged. On being transferred to Madras, I wrote to the Surgeon General asking when I might expect leave and I now quote from a reply by his personal assistant dated 23rd May 1914:—

"As you are aware, the leave rules are working out very badly for all in this Presidency. Only officers pucca in civil with 2½ years' furlough due to them are able to go away on furlough this year. Study leave is impossible to get now and will have to be taken out of an officer's furlough when he goes on it.

Majors Elwes, Ross, Chaudri and Symons have respectively 2 years and 10 months, 2 years 10½ months, 2 years 7½ months, and 2½ years due to them, exclusive, of course, of all study leave, and they are the only officers who can get away this year. Several others have applied but cannot go. Next year it will work out much the same. So it comes to this, when you are pucca in civil with at least 10 years' service, you stand a chance of going on furlough."

I hold, Sir, the very gravest censure on those who have passed orders concerning the welfare of the officers of the Indian Medical Service. The matter has not, I believe, rested with the administrative heads of our

own service. I have read magnificent letters from the Surgeons General of Madras and of Bombay to their respective local Governments concerning the prospects of the Indian Medical Service officers serving under them. I have seen a letter from our late Director General to the Government of India, in which he states, in two successive paragraphs, that "*he deemed it his most solemn duty to warn the Government of India*" of the result of their persistent neglect of our service.

Before turning from this question of leave, I would point out that instead of easing the leave problem, orders have been successively issued, rendering the obtaining of civil leave even more difficult than it was before.

In the first place, the percentage of Indian Medical Service officers allowed away on civil furlough was formerly calculated on the total number of Indian Medical Service officers in the Province, whether permanent or acting. A regulation was then introduced whereby the percentage was in future to be calculated on the "permanent" officers only, and thus, in the Madras Presidency, two furlough vacancies per annum were lost to Indian Medical Service officers.

In addition to this reduction, a far more serious restriction to the Indian Medical Service leave was imposed by correction slip No. 337, dated 2nd January 1914 to article 309 of the 5th Edition of the Civil Service Regulations. Because of its essential importance I enter into the point introduced by this correcting slip in some detail. The first paragraph of the regulations for the grant of study leave (an extremely wise and popular innovation) to officers of the Indian Medical Service, dated at the India Office, October 1910 and published in the *Gazette of India* runs:

"Extra furlough for the purpose of study may be granted

There was no doubt that it was intended that study leave should be regarded as *extra* furlough and it was at first so regarded. As a result of this non-provision of a study leave reserve the inevitable was bound to happen, and when it was realized that leave difficulties were becoming acute, instead of doing the *right* thing and putting down the necessary money to provide for a study leave reserve, the above quoted insignificant correction slip was added to regulations, whereby study leave in future was to count against furlough vacancies, and the last hope of many junior Indian Medical Service officers of obtaining leave home before they were bald and grey haired vanished. I hold, Sir, that the correction slip was contrary to the intention of the Secretary of State and gave evidence of an administration entirely out of touch and apparently entirely out of sympathy with the Indian Medical Service.

A week ago it fell to my duty to attend a particularly gallant and capable Indian Medical Service officer who had developed pneumonia after influenza contracted from Government servants he was attending. This officer had some thirteen years' service, chiefly as a junior Calcutta surgeon and has never enjoyed any long leave whatsoever. On what we all believed to be his death-bed, he begged me to endeavour to bring home by every public and private means possible, the condition of slavery as regards leave into which some Indian Medical Service officers had been driven and to which in many cases their healths and prospects had been sacrificed.

I trust, Sir, that whatever regulations for leave your Committee may introduce for the future, it will so far as possible undo this wrong Indian Medical Service officers have suffered from in the matter of leave, and will provide some guarantee that officers of many years' continuous service in the East will obtain long furlough to Europe proportionate to their service already spent out here.

It will not, Sir, in all human justice, suffice to now grant officers of 10 and 12 years' continuous service in

21 February 1919.]

Captain H. STOTT.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

India, 7 months' leave at Home and to wipe out the debt Government has already contracted in the past. Many of us in such a position are looking forward to the two years at Home essential to recoup our healths.

Secondly, a substantial cause for complaint as regards "pay."

With many of my brother medical officers I have failed to appreciate the attraction of the Indian Medical Service as a business proposition from the financial standpoint. I am willing to place my profit and loss account before you should that be of any assistance in your deliberations.

I would add under this heading two further notes concerning pay.

The first deals with exchange compensation allowance. I have here the memorandum given me by the India Office on my joining the Indian Medical Service which I regard as a form of contract. Dealing with the exchange compensation allowance, it reads: "Under present arrangements, officers of the Indian Medical Service receive exchange compensation allowance to compensate them for the fall of the value of the rupee. The allowance consists of an addition to their salaries, etc." At a time when the purchasing value of the rupee had fallen some 50 per cent. lower than when I joined in 1908, the Government of India saw fit to do away with this allowance without providing recompense in other directions.

The second note concerns a more personal matter.

On joining the Hospital ship "Madras," I was informed by the Assistant Audit Officer, 9th Secunderabad Division, that in accordance with regulations (para. 153 II, A. R. I., Volume I), I was entitled to grade pay plus half the staff salary of my civil appointment *viz.*, Rs. 725 per month. This was later confirmed by the Divisional Disbursing Officer, Poona Division, and increased to Rs. 750 on my attaining 7 years' service. The sum was paid out for some 18 months at this rate when the Government of India saw fit to eliminate their old regulation and reconstruct this particular paragraph to *their own* financial advantage only and to my personal disadvantage (and to that of all other Indian Medical Service officers affected to the extent of Rs. 100 per month.) I appealed to the Director, Medical Service, India, against this reconstruction, but without success.

I may add that the civil appointment I vacated was carried on as an additional charge by another Indian Medical Service officer who drew half the salary of that appointment. The Financial Department of the Government of India was, therefore, profiting to the extent of Rs. 500 per month or Rs. 26,000 to date on this one appointment alone; that is one side of the picture.

Within the past few months, for the first time in my service, I have known two Indian Medical Service permanent captains have their cheques dishonoured and one threatened with legal proceedings on account of bills, for which no provision existed.

The Government of India has thus saved vast sums in cash from pay due to the Indian Medical Service, and before reforms are introduced for the future this debt contracted in the past, which has seriously financially affected many of us, requires recognition.

Thirdly, a substantial cause for complaint as regards "allowances."

The allowances paid to Indian Medical Service officers require a substantial increase. I instance the additional appointment of civil surgeon, Bannu, which at present I hold. For this appointment, with the administration and medical and sanitary responsibility for the 250,000 population of the district, including free attendance on Government officials, the allowance is Rs. 100 (£7 sterling) per month. The figures speak for themselves without need of any additional comment whatsoever. I trust, Sir, your Committee will give

this question, of a proportionate increase in the present rates granted for allowance, the attention it needs.

Fourthly, a substantial cause for complaint as regards "promotion."

During the war, the Indian Medical Service has suffered severely in the way of lack of promotion as compared with other units. Non-medical officers greatly junior in service to Indian Medical Service officers have been promoted in every branch of the army to senior rank and to appointments with increased pay. In the Bannu Brigade, the aged appearance, prolonged service and junior rank of the permanent Indian Medical Service officers is a standing station joke. To furnish one example, the Deputy Assistant Director, Supply and Transport, Bannu Brigade, was in the same regiment as myself in Mandalay in 1911. He was a lieutenant, I a captain. He is now a major with double the income of an Indian Medical Service captain of my service.

I have frequently been asked what Indian Medical Service officers have done not to have been promoted.

This, Sir, is an additional cause of discontent in the service.

Fifthly, a cause for complaint, as regards "free passage home."

In East Africa I was sent on duty to Nakuru, and stayed there with a certain Dr. Spence of the East Africa Medical Service. We discussed the respective conditions of service under the Colonial Office and the Indian Government. He told me that in East Africa, Europeans could possibly obtain 6 months' leave after 2 years' service and were practically ordered home for 6 months after each 2½ years' service. Leave pay was at full duty rates, and first class passages were provided at Government expense on both voyages, with half passages for wives. If I remember correctly, leave did not start until England was reached.

In my humble opinion, there should be no reason for difference in the treatment of European officers by the Colonial and Indian Governments, save perhaps that in the latter case the leave might be more advantageously placed at one year after four years' service. The climate of the central plateau of British East Africa was glorious.

All European officers of Government should be guaranteed 1 year's furlough after 4 years' of service, a free passage Home and back, and half passages for family. Medical evidence could be brought forward in favour of this.

To my mind this recommendation is essential, and if taken up in the right way would receive universal support, and would be carried through successfully. It would secure certain leave and certain passage to the European officer of Government, for many of those who can obtain leave, find a difficulty in paying for the fares Home.

Business firms deal in a similar generous fashion (as regards free passages) and frequent long leave for the Europeans they employ.

3. Have you met with any instances of friction between the Royal Army Medical Corps and Indian Medical Service?

No, for I have not been in touch with such troubles, but many Indian Medical Service officers have complained of the bias of the Royal Army Medical Corps administration in favour of their own officers which is, after all, only to be expected in any great body of officers possessing a strong *esprit de corps*. Indian Medical Service officers from France especially complained of this.

I quote the following authentic case, because it is necessary to bring home proof of the existence of friction and jealousy, so that later the great importance of one unified medical service for India may be emphasised.

Firstly, I would make it quite clear that I have received many kindnesses from senior Royal Army Medical

21 February 1919.]

Captain H. STOTT.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

Corps officers, and have many personal friends in that Corps, and possess the greatest admiration and respect for all the vast constructive work they have accomplished.

When, in about 1915, after the Royal Army Medical Corps Director, Medical Services, was found medically unfit and when it became necessary to select a most efficient officer of great experience, especially to deal with the problems of the Mesopotamian campaign, there was, on the spot, one of the most brilliant Indian Medical Service officers the service has produced, and in accordance with the regulations which permit an Indian Medical Service officer to be appointed, the Government of India offered this Indian Medical Service officer the appointment and indicated that it should be a permanency for the war. The selection was, I believe, approved by the Secretary of State.

When the Royal Army Medical Corps at the War Office heard of this, after the Indian Medical Service Director, Medical Services, had held his appointment for two months, they wired to say that an Royal Army Medical Corps Director Medical Service had already left Marseilles to take up the Director Medical Services' appointment, and the Government of India, the Secretary of State for India and the regulations which provide for the appointment of an Indian Medical Service officer to be Director Medical Services, India, were overruled by the arbitrary power of the Royal Army Medical Corps at the War Office.

Our Director General was then gazetted a lieutenant-general, presumably as some reward for his prolonged and meritorious services. Immediately, a wire was received from the War Office, promoting the Royal Army Medical Corps Director Medical Service for few days service only to be lieutenant-general, and not only this, but his promotion was antedated a few hours before that of our own Director General's.

There is little doubt that the bias here exhibited in favour of the Royal Army Medical Corps has resounded, mostly perhaps unconsciously and mostly perhaps in a minor key, whenever the two services work together, since the ultimate support, the ultimate advantage of officers of our sister service.

In this connection, it may be noticed that all ten appointments for Deputy Assistant, Director Medical Service (Sanitary) in the ten divisions which carry good staff pay, and are at good headquarters stations are reserved for Royal Army Medical Corps officers whereas other specialist appointments are shared. This is irregular.

I notice in some places a suggestion that Royal Army Medical Corps and Indian Medical Service pay should be equalized. This would be under present conditions most unfair, in that the Royal Army Medical Corps are provided with free passages to England, serve for the most part with British troops in better stations than Indian Medical Service officers and are usually given a tour of duty in the hills.

4. Have you any improvements to suggest which would neutralize grievances or frictions?

Yes.

Firstly, and most essentially by the adoption of a genuine scheme for one unified military medical service only in India. Scheme 'A' is the only scheme, in my opinion, which offers a satisfactory solution in this respect.

Secondly, should this be impossible, then the office of Director, Medical Service, should alternately be held by a Royal Army Medical Corps and Indian Medical Service officer to eliminate the bias, which is bound to exist if an officer from one service only be repeatedly appointed.

Thirdly, the Government of India should introduce an authoritative body prepared to deal generously with the affairs of its European officers, so that never again any of its services may suffer, as the Indian Medical Service has suffered, from neglect of its just requirements. If the want of such a body has been felt in the past, it will be rendered far more desirable in future

with the advent of Indian ministers and the new reformation schemes.

5. What do you consider as the limit of service that should be fixed for—

(a) transfer from military to civil.

(b) transfer from civil to military.

(a) after 5 years' military service.

(b) before an officer reaches 20 years' service at the outside, he should decide whether he will remain in civil and never revert to military, or return to military and never again revert to civil.

Answers to special questions.

1. How far do you think that the demands of European members of the Public Services for European medical attendance are based on purely racial predilection, and how far on the comparatively professional merits of doctors educated entirely in the United Kingdom or in India?

In my opinion, the choice is largely a racial and a natural one. In this respect, I may add that there has been an increased strain thrown on the few available European Indian Medical Service officers recently who have been called upon to treat the European officers of Indian regiments, who have in no way appreciated the temporary Indian Medical Service officers provided for them.

2. What do you say as to the efficiency of Indian medical officers of various grades? Have such officers improved or deteriorated in efficiency in recent years?

I would reply that Indian Medical Service officers of all grades were an extremely efficient set of officers. Their knowledge of regulations and the smartness of their uniform may not perhaps have always been of the best, but their professional skill, their sportsmanship, their devotion to duty, their breadth of mind and their adaptability to any work on hand, has made me proud of the day on which I received my commission in His Majesty's Indian Medical Service.

It should be remembered that Indian Medical Service officers are passing through an exceptionally hard time, working with untrained Indian subordinates, and endeavouring to constantly stimulate the patriotism, energy, interest and manners of a vast number of our temporary confrères. This has imposed an additional heavy executive strain, which has, I think, been scarcely realized by administrators.

I regard the various types of work required of an officer of the Indian Medical Service as affording the very highest educational opportunities, and but for the shameful neglect of the service in the matter of pay and leave, I would regard the Indian Medical Service as offering the finest career a medical man could desire.

The urgent want of leave in the service long before the war was bound to have one effect, and one effect only for those who paused to think in service matters, a deterioration in efficiency. It is a magnificent testimony to officers of any service.

It is a magnificent testimony to the mere handful of the 600 or so European officers of the Indian Medical Service that without European reserves and without European staffs and dealing as they do with all varieties of nationalities in the way of patients, and neglected as they knew their prospects were, frequently hearing adverse criticism from the Royal Army Medical Corps and from the Indian press and public without any opportunity to reply, they have carried through the civil and military requirements of India and of the numerous Indian Expeditionary Forces in the magnificent way they have done.

Many of us are now seriously and mentally worn out for want of leave beyond all telling.

Answers to questions for witnesses.

1. What defects have you noticed in the organisation on the Royal Army Medical Corps and the Indian Medical Service in India?

21 February 1919.]

Captain H. STOTT.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

The only defect, and a most grave one, to which I will refer here is the condition into which the leave, pay and prospects of Indian Medical Service officers, especially those in civil employ, have been allowed to drift.

Does any one of the attached schemes commend itself to you; and if so, which and why?

Yes, scheme 'A'.

Firstly, and *above all* because, in my humble opinion, the time has now come when passing personal and service interests should be sunk in order to strengthen as far as possible the bonds of Empire.

Organisation of the military medical arrangements in India by Royal Army Medical Corps provides a powerful and indissoluble link with Home. That Corps has an authority and efficiency which none would gainsay, and it has the medical profession of England behind it.

The alternative to strengthening this link bond with Great Britain is the setting up of a new local service in India, between which and the Royal Army Medical Corps there will always be a substratum of friction. In effect we shall be loosening the bonds of Empire by raising a military medical service in India somewhat antagonistic, or at least not in whole-hearted co-operation with the Royal Army Medical Corps at Home.

On my way to Delhi, I have been reading Colonel Murray's 'Imperial Outposts'—and I now quote two sentences from Earl Robert's preface to that book:—

"The writer dwells on the necessity for co-operative effort throughout the Empire. This is the correct note to strike, and one which cannot be sounded too often and too loudly in this country and throughout Greater Britain."

It is in concert with these words of the great Earl Roberts and in support of the closest possible co-operation on the medical service at Home and in India, that I now earnestly suggest scheme 'A'.

I trust, Sir, that your Committee will consider for a space of time, these schemes from the standpoint of the Empire, and should scheme 'A' be finally adopted, I feel sure, that when the next great war breaks out, as it assuredly will do, the value of absolute unison with the medical service at Home will become very apparent.

I feel, Sir, there is far more in this point than these few words of mine can convey.

The Royal Army Medical Corps is apparently willing to meet the requirements of India, and in the scheme submitted it would, I believe, undertake them with eminent success.

In the auxiliary corps, Indian and Anglo-Indian medical officers would find an opportunity of practically running their own show and of treating those officers and men of their own race in the Indian Army with intimate sympathy. They can freely develop their own *esprit de corps*. I regard this part of scheme 'A' as a particularly fortunate and appropriate solution to many difficulties.

There is a second point in scheme 'A' which strongly appeals to me. In the Royal Army Medical Corps, European officers can find a stimulus to their patriotism and *esprit de corps*. Friction and discontent amongst them will thus be non-existent or the more easily smoothed over.

The alternative schemes provide for an indigestible mixture of blacks and whites, and of whitish blacks and blackish whites.

It is, too, composed of a diverse conglomeration of officers of the Indian Medical Corps, of ex-Royal Army Medical Corps officers permanently transferred to that Corps and of Royal Army Medical Corps officers seconded for a few years to it.

In my opinion officers will be attracted to it very largely by financial considerations. The *esprit de corps* will mainly prove a superficial veneer, and causes for discontent and friction amongst its diverse component parts will be constantly present.

There is one objection to scheme 'A'.

Present officers of the Indian Medical Service will undoubtedly suffer under it. Some of those who transfer

or remain seconded will be regarded, mostly unconsciously, but still regarded, as interlopers from the "defunct Indian Medical Service." Their interest must be safeguarded as far as possible, and a definite bonus to cover past and future disabilities should be granted them. The auxiliary corps will of course find some other name than that of the Indian Medical Service.

2. Do you consider that the scheme which you commend (a) will meet with the approval of the War Office, and (b) that it will meet needs of the army in India, (c) have you any criticisms to make in either connection?

(a) Undoubtedly.

(b) None better.

(c) No, save that the Royal Army Medical Corps officers should be encouraged to renew periods of 5 years' service constantly in India, it being understood that, ordinarily, the longer the service in India, the better the chance of obtaining the higher administrative appointments such as Assistant Director, Medical Service, Director, Medical Service and as Director General.

3. Do you consider that the scheme which you prefer will attract a good stamp of recruits and meet the demands of professional opinion in England and in India?

If the scheme which you prefer fails in either respect, how would you remedy such failure?

I believe that scheme 'A' will prove by far the most successful scheme for attracting good European medical men from England, in that junior European officers will know that they come to India to serve only under officers of their own race. For this reason, I believe, that medical men of the best stamp will largely refuse to come abroad to serve under the vast kaleidoscopic personnel which is provided for under the alternative schemes.

I am in fairly constant touch with the Royal Society of Medicine, Guy's Hospital and the University of London at Home, and I believe this will largely prove the view their members will eventually adopt.

Since being summoned before this Committee and since drafting replies to your questions, I have discussed these schemes with four Indian Medical Service officers, the only ones with whom I have been in touch. All agreed that scheme 'A' was the best, and the more we discussed, the more clear did our view on this point become, though, as one officer remarked, we knew we were signing the death warrant of our Service.

I believe, the longer Indian Medical Service officers and the profession at Home discussed this question, the more in favour of scheme 'A' would they become.

To repeat in summary, the points essential, in my opinion, for the successful re-organisation of the medical services in India are:—

As regards the cost.

(1) Recognition of the grave financial disability under which many officers of the Indian Medical Service from both deficient pay and allowances and lack of promotion have suffered, and the grant of an adequate bonus to them as a recompense.

(2) Recognition of the wrong done them in the matter of leave in the past, and the placing of prolonged furlough in Europe at their disposal on a proportionate basis of the service they have already rendered in the East.

As regards the future.

(1) The adoption of scheme 'A'.

(2) The provision of free first class passage for all medical officers Home, once in 5 years, with $\frac{1}{2}$ passages for their families, and a recommendation from this Committee for the extension of this privilege to every

21 February 1919.]

Captain H. STOTT.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

European servant of Government on duty in India, so as to ensure of adequate leave being taken, which is essential on medical grounds for their efficiency.

(3) The establishment of some authority in India which will jealously and generously guard the interest of its European medical officers, and indeed, of all the European servants of Government.

(4) Adequate provision for furlough, study leave, with increases in pay and in allowances both civil and military.

4. What has been the result of withdrawing European officers from the charge of troops, civil districts and jails in India ?

The result has been to throw a larger additional strain on the European officers of Government who have remained on other charges.

As regards troops I can say from direct personal knowledge that the standard formerly accepted in the diagnosis of disease has fallen woefully.

5. Will the scheme which you recommend meet the needs of the Civil administration in India ?

I think so.

To what extent would it be affected by needs occasioned by war on a large scale ?

I do not think any scheme could meet any such emergency so well as scheme 'A.' We should have the whole of the Royal Army Medical Corps and its vast reserves in England behind us. The auxiliary corps should have, likewise Indian and the Indian practitioners behind it.

6. Would the scheme you recommend give a sufficient and efficient reserve for military purposes ?

See 5 above.

7. Do you consider that it is necessary to have a medical service reserve for war previously trained in military work and must such reserve be always actually present in India ?

With scheme 'A,' possibly not.

8. How far has the Indian Medical Service reserve (civil side) proved of value in the war ?

The Indian Army could not have carried on without it. Indian Medical Service officers from civil employ brought a welcomed atmosphere of broadminded criticism of expert professional skill, and freedom from red tapism to bear on many problems which arose.

9. What system of recruitment and education do you recommend as desirable for medical officers in connection with the scheme you prefer ?

As outlined in scheme 'A.'

10. Have you any suggestion to make as to the grants of special leave for study or as to prescribing periods of study ?

Study leave is of course essential, and an adequate leave reserve must be provided for it. I am decidedly of opinion that study leave should be available when asked for (within reasonable limits) and that no definite course or examinations be laid down so that officers may act on their own initiative and follow their own inclination, thus broadening the outlook of the service.

11. Have you any suggestions to make as regards the provision of a special department for research ?

Research is most stimulating to all advance in knowledge, and India affords especial attractions in this respect. A special department or sub-department should, without the least doubt, be formed.

12. How far has private practice declined in the case of officers of the Indian Medical Service in civil employ ?

Private practice is now practically non-existent save in a few special appointments. As surgeon to His Excellency the Governor, in just under 2 years, my income from private practice averaged Rs. 50 per month. As civil surgeon, Bannu, and Agency surgeon, Tochi, in 6 months, my income from private practice has been 7 visits at Rs. 16, or Rs. 112, and one certificate at Rs. 10.

If it has declined what are the reasons ?

The reasons are :—

- (1) The vast increase in Government work, with the result that the medical officer is too tired to tackle private cases.
- (2) The frequent transfer of officer so that he has no time to settle down, make a *landcast* for practising, and to get to know his patients.
- (3) The increased education of, and cheaper rates charged by, Indian practitioners.
- (4) The feeling by many officers that it is hardly fair to charge the families of European government servants for attendance, who are often personal friends.
- (5) And lastly, the point that in order to feel absolutely free in their opinion many Indian Medical Service officers refuse proffered fees, in return for certificates, medico-legal cases or other questionable occasions.

For this reason, I have always strongly held that Government should largely increase the civil allowances and pay of Indian Medical Service officers.

In conclusion, I apologise, Sir, for troubling you with so many details and trust that the evidence proffered may prove of some assistance to you.

CAPTAIN H. STOTT, called and examined.

(President.) He had spent most of his time in military. During the war he had served chiefly on the Hospital ship "Madras." He had been in civil employment at Madras for 1 year and 10 months with 6 months' additional collateral civil charges as civil surgeon, Bannu, and Agency surgeon, Tochi, in addition to military duties.

The details set forth in his written statement could be relied upon as he had consulted several officers.

He would not be satisfied with the recent increase of 33½ per cent. if it was based on the old grade pay.

He thought that the allowances given to Indian Medical Service officers for performing special extra duties should be increased. Rs. 100 for the civil medical charge of the Bannu district, staff surgeoncy and many other duties was manifestly inadequate.

With regard to the question of promotion he was of opinion that a grievance in the Indian Medical Service was that non-medical officers junior in service to Indian Medical Service had been promoted to senior rank in the army and to appointments holding increased pay.

He did not think that the temporary Indian Medical Service officers had done very well. They had probably

done their best but they were not of the stamp one would like to associate with. If they are too hard worked they usually break down. Their diagnosis had been extraordinarily bad.

He was in favour of scheme 'A.' He would like to have the auxiliary corps. He thought it would work well. He thought that one objection to scheme 'A' was that the present Indian Medical Service officers would suffer if their interests were not safeguarded. He suggested that they should be given a definite bonus to cover past and future disabilities. The Royal Army Medical Corps would naturally be more disposed to look after officers of their own corps than officers who entered their service from another corps.

He thought that the auxiliary corps suggested should have a name.

It was really the civil side that attracted him to join the service. The best men are usually attracted by the civil side as they are given vast opportunities for professional work.

In his batch they were at least 50 per cent. who hoped to get into civil. The other 50 per cent. contained a quarter of black men who simply joined to get a commission.

21 February 1919.]

Captain H. STOTT.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

(General He'ir.) He would not change opinion about scheme 'A' even if the present discontent in the Indian Medical Service was removed. He did not think any good Europeans would come out to India if they knew they had to serve under an officer whom they considered inferior. The prospect of being commanded by men of mixed descent would affect recruiting.

(General Hendley.) He anticipated no difficulty in getting men to join the Corps suggested in scheme 'A.' He thought that it would be satisfactory from the Indian point of view, though it could not quite take the place of the Indian Medical Service as far as sympathy went. He thought that he would get as good a reserve under scheme 'A' as under present conditions.

(General Giffard.) He was of opinion that the junior officers of the Indian Medical Service had lost trust in the Government of India who had failed to look after the interests of their service.

He would favour scheme 'A' as it would lead to a large number of Europeans joining it, and would be under the War Office and the Government in England.

He was of opinion that an officer going on study leave should be allowed to select his own courses of study.

If an Imperial civil medical service was set up he thought that good men would be forthcoming if the pay was attractive and they were guaranteed some of the best appointments. He, however, said that if these men had to compete with Indians very few would enter the service.

(Mr. Hignell.) With regard to the responsibility for the welfare of the officers of the Indian Medical Service he admitted there were two sides to the question but he was of opinion that the Indian Government were mainly responsible for neglecting the service.

He could not remember how he came to see the letters which he had quoted in his written statement.

THE HON'BLE KHAN ZULFIQAR ALI KHAN, C.S.I., called and examined.

(President.) The witness had studied all the schemes and considered that scheme 'D' was the best.

He lived in Lahore and had property in Delhi, Ludhiana, Simla and Lahore. In case of his own illness or illness in his family he called in Indian as well as European doctors. He had confidence in some Indian doctors and would generally call them but when expert opinion was required and in case of special emergency European doctors were called in. In case of illness of ladies he would call in European lady doctors and that was more or less the general practice among his class of people. As a rule they called in Indian doctors but in case of special emergency they called in Europeans and in the case of ladies they preferred European lady doctors. He had consulted only one Indian lady doctor (Miss Benjamin in Simla). This was partly due to the scarcity of Indian lady doctors and partly to the fact that the European lady doctors were more efficient.

Men of his class were beginning to put their sons into the medical profession as they were beginning to realise the advantages and attractions of the profession. He himself had two sons the elder being 14 years of age whom he wished to study agriculture and law as that was a good combination to enable his son to manage his estate properly. He intended that his second son should join the medical profession. He himself was educated at the Chief's College, Lahore, but had not taken any degree. He looked after his estate and took part in public life. The general predilection among the people of his class was for the executive provincial service. The legal profession was not very attractive at present as it was not very lucrative and was getting overcrowded. Taking all these things into consideration men in increasing number were going in for the study of medicine.

(General Giffard.) He knew some instances of private medical practitioners who had come forward to help Government in war but they had not proved quite satisfactory.

The question whether the Indian Army could expect a big help from the private practitioners in the way of a war reserve in the event of another war would entirely depend upon the education imparted in the medical colleges. If the standard of education there was considered good enough for the purpose, the Indian Army

could depend upon the private practitioners as war reserve.

There had been no change in the standard of education in the medical colleges in the last 20 years but he considered that a change was called for in the direction of bringing specialists of European experience and repute. The cost of bringing such men would no doubt be great but India ought to pay sufficiently to attract such persons.

(Mr. Hignell.) He was present at the debate in the Legislative Council regarding Mr. Sastri's resolution about the Medical services. All Indians except one, a Burman, voted in favour of the resolution. He himself had abstained from voting. He had since thought over the matter and was in favour of a unified service. There should be an open examination for recruitment in England and a simultaneous examination in India so that a larger proportion of Indians might be able to join it. In order to keep up the spirit of the profession and the efficiency of the service in regard to administrative control, etc., he considered that at least 50 per cent. or even a little more should be Europeans.

(General Hendley.) He wanted one of his sons to join the medical profession and to qualify himself for the Indian Medical Service. The attractions to the Indian Medical Service consisted in the military rank, the prospect of a transfer to the civil side and the good practice it afforded. He would no doubt desire the transfer of his son to the civil side which was one of the chief attractions of the Indian Medical Service.

The Indian Medical Service had met all the needs of India in the past and the only good reason for changing the system was that a greater proportion of Indians should be admitted into the service. Except for the fact that there were not sufficient Indians in the Indian Medical Service it was in every way satisfactory.

(General Cree.) He did not think that generally speaking it would be deterrent to the Indians who joined the Royal Army Medical Corps that they would have to serve in all parts of the empire and that they might have to leave India not to come back say for 20 years except on periods of leave. This was true of the Muhammadans as well as the Hindus who cast aside their prejudices when they went to foreign lands. As a matter of fact some Indians who have joined the Colonial service could not come to India except on leave.

22 February 1919.]

The Hon'ble Colonel R. C. MacWatt.

*(The schemes and questions referred to by witnesses are contained in Volume III.)***At Delhi, Saturday, 22nd February 1919.****PRESENT.****THE HON'BLE SIR VERNEY LOVETT, K.C.S.I., I.C.S. (President).****MAJOR-GENERAL G. CREE, C.B., C.M.G., A.M.S.****MAJOR-GENERAL P. HEHIR, C.B., C.M.G., C.I.E., I.M.S.****MAJOR-GENERAL H. HENDLEY, K.H.S., I.M.S.****THE HON'BLE MAJOR-GENERAL G. G. GIFFARD, C.S.I., I.M.S.****S. R. HIGNELL, Esq., C.I.E., I.C.S.****LIEUT.-COL. A. SHAIRP, C.M.G., Indian Army.****MAJOR M. T. CRAMER-ROBERTS, D.S.O., Indian Army.****MAJOR A. A. MCNEIGHT, I.M.S. (Secretary).****The HON'BLE COLONEL R. C. MACWATT, C.I.E., I.M.S., representing the views of the Government of the Punjab.***Written statement.*

I am instructed to say that the Punjab Government owing to the pressure of more urgent work has not had sufficient leisure to study the subject thoroughly in the limited time allowed.

But it provisionally accepts the views stated below, which are the result of discussion between the Inspector-General of Civil Hospitals and the Punjab Government. The additional cost will no doubt be considerable, but will have to be faced.

The maintenance of a strong European element in any Indian Medical Service constituted is essential for many reasons, *e.g.*, the steady growth in institutions for medical relief and in the medical staff, the growing importance of efficient control of subordinates in whom the spirit of discipline and duty is not always high, the great importance (in the Punjab) of medico-legal work, the rapid development of the Province, the increasing size of stations and the expediency in the interests of the services and of their future recruitment of providing skilled medical aid, as otherwise the effect on recruitment in regard to these services will be most serious.

I. The desirability or otherwise of the creation of an unified medical service for India both for military and civil duties.

The Royal Army Medical Corps claim to be a purely British service to which Indians are not admitted.

The tour of service of Royal Army Medical Corps officers in India is limited to a few years at a time; few of them have any useful knowledge of Hindustani or of the habits or customs of Indians. Indians are admitted to the Indian Medical Service; it is understood that the proportion of Indians will be increased in the immediate future. Indians will no doubt be appointed to 'command' of station hospitals and administrative rank.

Objections to Indian commissioned officers attending British troops; their wives and families would be real and probably insuperable. It would not appear desirable to amalgamate medical officers of the British and Indian services in one unified service for India. The need has not arisen in the case of combatant officers of the British and Indian armies. If Royal Army Medical Corps and Indian Medical Service are allowed to exist, as at present, the Indian Medical Service should have at least the same standing and privileges as the Royal Army Medical Corps; an equal number of administrative military appointments and the office of Director of Medical Services should be held alternately by an officer of the Indian Medical Service and the Royal Army Medical Corps especially as now the station hospital system for Indian troops has been introduced.

II. If it is decided to proceed with the formation of such an unified medical service for India what would be the best method of carrying out the proposal?

An enlarged Indian Medical Service, or Indian Medical Corps (Royal or otherwise) to take over all the duties in India connected with both British and Indian troops and civil work.

Medical officers who spend all their active lives in India are more likely to be in touch with the requirements of the country, and best fitted to advise regarding the welfare of British and Indian troops from medical and sanitary points of view. This applies also to the post of Director, Medical Services and administrative appointments.

Officers in the Royal Army Medical Corps, in the early part of their service, might have the option of transfer to the Indian Medical Service or Corps, either temporarily or permanently if found suitable. In the former case they would draw Indian pay and allowances, in the latter they would qualify for Indian pension. They would in fact become integral parts of the Indian Medical Service or Corps.

III. The relation to or the inclusion of subordinate medical services in an unified service.

For the superior ranks the system prevailing in the Indian Medical Service is the best imaginable for the needs of India—Medical Officers trained and disciplined in military service and drafted into civil as required; and always liable to be reverted to military if found unsuitable for civil work in India, or if the exigencies of the service demanded. If civil assistant surgeons and sub-assistant surgeons were trained as military pupils and were passed out of the medical colleges and schools into military service when they would be liable to do a period of military duty, and were drafted into civil appointments as required; while at all times or for, say, the first fifteen or twenty years they would be available for military service, the arrangement would be only for the advantage of India; while discipline would benefit them physically, morally and mentally. And a large reserve would exist to draw upon for military requirements in times of need.

The unified Indian Medical Service or Corps should include:—

- (1) Medical commissioned officers.
- (2) Military and civil assistant surgeons (who might be designated as Class I).
- (3) Military and civil sub-assistant surgeons (who might be designated as Class II).
- (4) Compounders—these should also be primarily military and transferred to civil hospitals and dispensaries. They would be liable to be called up in the case of military necessity. In this way a good reserve of compounders would be formed. Those remaining on

22 February 1919.]

The Hon'ble Colonel R. C. MacWatt.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

military duty would be infinitely superior to military ward orderlies who, it would appear, are too often sepoys handed over from regiments because they cannot shoot well, or do efficient combatant work, or mentally obtuse, or for some other reason; and they are frequently unsatisfactory for hospital work.

(5) Army Bearer Corps.

(6) Hospital clerks, store-keepers, etc.

IV. *Maintenance in civil employment of an adequate war reserve in the ranks of both superior and subordinate services.*

The civil medical department is seriously undermanned so far as European commissioned officers are concerned. More civil surgeoncies should be reserved for them. Surgeons-general and inspectors-general of civil hospitals should in large provinces have European Indian Medical Service officers as deputies or assistants, as the work is too much to be always efficiently performed by single handed, and they have practically no leisure.

Civil surgeons of many large and important stations or districts, e.g., Lahore, Rawalpindi, Agra, Allahabad, Ajmer, should have a joint civil surgeon as at Simla or assistants from the commissioned ranks. (Deputy commissioners have assistant commissioners, Indian Civil Service, serving under and assisting them). The medical work at headquarters and in the district would be more efficiently performed. There should also be an increase of commissioned medical officers serving under sanitary commissioners.

A substantial reserve would thus be built up available in war time.

Military assistant surgeons should have qualifications registrable in the United Kingdom; their professional training and attainments are not inferior to those of Indian university graduates. The number of military assistant surgeons in civil employ should be increased—at least one is required for each railway community of any magnitude which includes European and Anglo-Indian employés and their families; in large railway centres two ought to be appointed.

In some of the larger civil stations military assistant surgeons should be posted as second assistants to the civil surgeons; and in civil stations of any size where Indian Medical Service officers are not supplied as assistant to the civil surgeons, they might be appointed instead.

Civil assistant surgeons under this scheme would be primarily military and liable for military duty; so the name would have to undergo some change. Their numbers should be increased, and one ought to be posted to each important dispensary; in some cases, as required, with a sub-assistant surgeon working under him.

The cadre of sub-assistant surgeons should undergo a large increase for the staffing of many new district dispensaries which are required. In the Punjab this important point is receiving every consideration and rural dispensaries are being constructed and opened as rapidly as funds permit. In the near future it is hoped that even greater activity will be exhibited in this measure of bringing medical relief within reach of as many of the people as possible.

V. *The relations between independent medical practitioners in India (both European and Indian) and the unified medical service, with special reference to the formation of a war reserve of all ranks.*

This is considered to be a negligible quantity as demonstrated in the recent influenza epidemic when the services of independent medical practitioners in large numbers to assist Government would have been very welcome.

In the Punjab it is believed that the vast majority consist, of those who have failed to obtain Government service, or have retired, resigned, or whose services have been dispensed with therefrom. Those with good practices are unlikely to relinquish them in war time when their incomes are liable to considerable increase due to the withdrawal of Government doctors. Those with meagre and precarious incomes would not be of much use should they join up; their reasons for so doing in many cases would probably be because they had no substantial practice to abandon and they would be attracted by what would be, to them, good pay. This has been the experience during the present war.

Under present conditions in India much assistance from this class so far as the Punjab is concerned cannot be hoped for. The relations between them and the unified medical services in India would be much the same as in England, which in times of peace are practically nil. A certain number there hold commissions in the Territorial forces. In India the services of non-Government doctors belonging to the Indian Defence Force such as railway medical officers (who are not independent practitioners) and others would be utilised with Indian Defence Force units.

Mission doctors also are not independent practitioners; some might volunteer for war reserve as they have done previously—most of them in their own districts or in India.

Medical Stores Department.—This question is being separately dealt with by the Medical Store-Keeper. The Punjab Government do not see why they should be bound to purchase all their medical and surgical requirements from the depots of Government Medical Stores if they can get better articles on more favourable terms elsewhere.

The Hon'ble Colonel R. C. MacWatt, C.I.E., I.M.S., called and examined.

(General Giffard.) His Government would be contented to continue to give Indian Medical Service military officers all superior appointments, if the Government were permitted to choose outsiders themselves for special appointments, when they wish to do so. He agreed that such appointments could be filled in India without going outside for candidates. With regard to filling vacancies by means of advertisements in the newspapers, there was a Government ruling that appointments in medical colleges should be reserved for Indian Medical Service officers. All superior medical appointments as well as those in medical colleges held by superior officers are to be held by officers in the Indian Medical Service.

The question of the increase of officers in superior appointments in civil cadre from the Indian Medical Service and from outsiders had not engaged the attention of his Government.

The question of the increase of cadre was receiving the consideration of the Punjab Government.

With regard to the formation of a reserve from the independent profession, in future, so far as the Punjab Government was concerned, it was considered that such a reserve could not be formed in the near future.

The question of leave to Indian Medical Service officers was a very difficult one, due to the shortness of the cadre.

With regard to the question of giving free treatment to the families of all civil officers in the outlying districts of the province, he was afraid that he would be unable to answer the question without reference to Government and time to think it over.

The expense incurred by civil officers in having to send their families to hospitals for treatment was a cause of complaint at present throughout the Punjab.

He was unable to reply to the question whether he would be in favour of appointing two or more travelling consultants and travelling medico-legal experts in the province, as he had not given the matter sufficient consideration.

22 February 1919.]

The Hon'ble Colonel R. C. MacWatt.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

He would have to consult his Government with regard to the question of allowing Indian Medical Service officers in civil employ to return for one year at the end of each 5 years to the army.

With regard to meeting the aspirations of Indian graduates towards a larger share in the superior civil and medical educational appointments, arrangements were being made. They were opening up a new medical school at Amritsar, which would employ a certain number of Indian teachers. They were also opening up a great number of dispensaries, which would be in charge of assistant surgeons, and, taking it altogether, there was a good deal of progressive advancement with regard to meeting the aspirations of the Indians. He did not think this was likely to be done at the expense of the commissioned Indian Medical Service officer, as the Punjab Government was pressing for more commissioned officers, there being very few in the province.

There has been considerable falling off in the quantity and quality of the civil medical work during the period when Indian Medical Service officers were recalled to military duty. The civil surgeons had kept up the number of operations returned but medical work had decreased. The civil officers who had replaced the Indian Medical Service officers were not of the same professional efficiency. Administrative efficiency had likewise decreased in quality.

(President.) The Punjab Government were not in favour of amalgamation; but if amalgamation were to be resolved upon, they would desire it to be conducted on the lines suggested in paragraph II of the written statement.

(General Hehir.) A reduction of Indian Medical Service officers in the Punjab would hamper the development of medical officers in various directions, and an increase, rather than a decrease, of Indian Medical Service officers was indicated.

The military medical officer was *ipso facto* better for a large number of the superior civil appointments than purely civil practitioners.

(General Hendley.) The Punjab Government contemplated increasing its Indian Medical Service civil service by 8 Indian Medical Service officers. The question of asking the Government of India for an extra Indian Medical Service officer for the Medical College was under consideration; also for the Medical School at Amritsar.

With regard to the great stress that this Government laid upon the necessity for skilled medical advice for officers in the public services, the witness cited a number of cases where considerable lack of efficiency had been displayed by Indian medical officers, both Indian Medical Service and independent practitioners, which had led to serious complaints from European officials.

DR. B. T. HOLLAND, M.B., Ch. B., F.R.C.S., Residency Surgeon and Chief Medical Officer in Baluchistan.

Written Statement.

DEFECTS.

That specialists are withdrawn from their work at a time when they are often at their prime in order to get promotion.

That after a long period of civil employ, officers are recalled to military to hold the office of Assistant Director of Medical Services when they have been altogether out of touch with the military department for years.

On the whole I favour scheme A with the following modifications:—

1. Military rank ought to be given to officers of the civil medical service

- (a) Because the holding of rank in India undoubtedly gives the officer a certain definite status and a position of authority with the Indian.
- (b) Because men, as a rule, like to have rank and it gives them a position on retiring from the service in England.
- (c) It prevents odious comparison with officers of the Royal Army Medical Corps, who hold military rank.

The difficulty of giving rank to purely civil officers could be got over by giving them commissions in the Army Reserve, like the territorials at Home. They would begin as lieutenants and then receive promotion as in the Royal Army Medical Corps.

Consultants ought to be selected from specialists and not brought out from Home.

- (a) The best will not come out from Home, as they would lose touch with their patients at Home.
- (b) Few consultants at Home are authorities on tropical diseases, few are conversant with Indian habits, views, customs, etc.
- (c) If the consultants hold the same rank and emoluments as an Assistant Director, Medical Services, it would make the service more attractive.

The forming of a military medical department entirely separate from the civil, as in scheme A, ought to meet with the approval of the War Office, and meet the needs of the army in India, provided that there is a

sufficient military reserve, for all officers in the military medical service would, of necessity, be more *au fait* with their military duties than can be the case at present when so many officers of the present Indian Medical Service are in civil employ.

I consider that scheme A, modified as I have suggested, would attract a good stamp of recruits, but to my mind the whole crux of the problem is the percentage of Indians who are to be admitted to the Service. That ought to be stated clearly and definitely, or recruits at Home will be suspicious.

This is also necessary in order to ensure that there should be at least one European doctor at each centre where there are English officials and their wives. Stress is laid on this point in section 22, scheme B.

The withdrawal of European medical officer has, in my opinion, been prejudicial to discipline and efficiency.

The needs of the civil administration in India would be affected by a war on a large scale, as they have been in this war.

But if an additional war reserve could be formed consisting of private practitioners, European and Indian, they could take the place of officers of the civil medical service called up for military duty.

Baluchistan has been able to carry on its medical administration with very few qualified men, most of them holding rank as sub-assistant surgeon, being compounders and vaccinators.

There were before the war two military assistant surgeons and three civil assistant surgeons and thirty-seven military sub-assistant surgeons. Now there is one military assistant surgeon and three civil assistant surgeons, but only 15 qualified sub-assistant surgeons of whom two are military, nine are civil, and four are retired sub-assistant surgeons; the remaining 15 are promoted compounders and vaccinators, etc., and on the whole they have discharged their duties well.

As regards a military reserve of assistant surgeons and sub-assistant surgeons, their difficulty might be met by making a stipulation that every student at our medical colleges and schools holding a scholarship, shall come up for military duty when called on and that every three years they would have to put in one

22 February 1919.]

Dr. B. T. HOLLAND.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

month at a military hospital in order to keep in touch with military methods. From my experience of two years as Principal of the Hyderabad Medical School, I know of no other method for ensuring a military reserve of assistant and sub-assistant surgeons.

I recommend that all medical officers in connection with the new scheme would hold British diplomas.

I believe that private practice has declined and will continue to decline still more owing to the following reasons:—

- (1) Because of the large number of qualified private practitioners.
- (2) Because the Indian goes for the cheaper articles and the Indian doctor as a rule undersells the English.
- (3) On patriotic motives the general tendency being to encourage everything Indian and decry everything English.

Answers to special questions.

The demands of European members of the public services for European medical attendance over themselves

DR. B. T. HOLLAND, called and examined.

(President.) The witness is the Chief Medical Officer in Baluchistan. He came out to India in 1900 just 19 years ago. He had spent the first 15 years in the mission hospital and had been in the Government service for the last four years. Except for some time when he was employed as civil surgeon, Hyderabad (Sind), he has spent the whole of the period in Baluchistan.

He favoured scheme A with certain modifications suggested in his written statement. He had not had time to study the papers carefully and had only been able to suggest a skeleton outline.

The civil side should be entirely divorced from the military, first of all because if a man knew exactly what he was going in for he would be better able to make up his mind. Many persons were not keen for the military and were very good at their profession. To such persons the military career would have no attraction. Secondly, under the present system the great trouble was that a man was taken away in the prime of his life for military duty and was detailed to do administrative work in order to get promotion. This was a very unsatisfactory system as it interfered with a man's professional work. As a matter of fact under his scheme the military and the civil would attract two different kinds of men, the military attracting the men with whom the military career counted and the civil would attract the men who wished to be doctors exclusively. The civil department should be practically the military reserve like the territorials at Home so that they can be called on when necessary. The point on which he wished to lay stress was that there must be a good military reserve. If it was known that the men would have territorial rank as territorial officers at Home it would be a great attraction. It would thus be possible to have a militia reserve in addition to the regular reserve. A certain number of private practitioners both Indians and Europeans should also be enrolled for the purpose so that if the main military reserve was taken away it would be possible to fall back on the second reserve of private practitioners. The military reserve would thus consist of two kinds. There would be a regular military reserve consisting of military men who were seconded, and besides there would be men who, though they would be civil officers, would be liable to be called to the army in time of great pressure.

The medical staff at present in Baluchistan was very small as practically all the men had been taken away for military purposes.

Private practice had declined for the various reasons given in his written statement one of which was that of patriotic motives, the tendency being to encourage everything Indian and to decry anything English. This remark did not apply to Baluchistan where the people

and their families are, in 80 per cent. of cases, based chiefly on racial predilection.

To my mind it is not so much a question of the comparative professional merits of doctors educated entirely in the United Kingdom and those educated partly or entirely in India, but it is the personal factor. As far as my experience goes few Indians have the necessary self-confidence and especially if called in to treat a high Government official are apt to lose their heads. I have known this in several cases. Also they, as a rule, have extremely receptive minds, but are not practical and do not inspire English patients with confidence.

Europeans have not, as a rule, been satisfied with Indian substitutes for European doctors withdrawn from the charge of troops and districts though there are many exceptions.

When not satisfied they either have to be content with what they have or go elsewhere for treatment, often at great expense.

Most of the Indian medical officers I have met in civil employ are most efficient and it has always struck me that the keenest and best professionally do go into civil.

were not highly civilised, but this tendency was distinctly noticeable in Sind.

The remark in his written statement to the effect that most of the Indian Medical Officers whom he had come across in civil employ were most efficient applied to the Indian Medical Service officers. It had always struck him that the keenest and the best professionally got into the civil line.

(General Giffard.) The purely civil medical service, sufficiently trained to form a war reserve, would succeed in recruitment in England and would differ from the military medical reserve inasmuch as the men desirous of joining the civil service would know definitely the work they would have to do, and that their chances of going in for military duty would be remote.

No doubt there was a danger that the purely civil medical service would shortly become entirely Indianised, but this should be carefully guarded against. *That was in fact the crux of the question.* The main question was how many British officers were to be retained in this service and for this purpose he would like the proportion of such men to be fixed.

(Mr. Hignell.) He had carefully thought over the method by which a certain proportion could be kept up. If the examination was an absolutely open one and if a certain percentage of Indianised Europeans to be admitted to it were laid down it would cease to be an open examination. But if it were made an open examination for Indians and British alike and at the same time, if say, 40 per cent. of the members of the Royal Army Medical Corps or the Indian Medical Service were seconded to the civil department it would prevent the examination from being an unfair one and at the same time effect the desired object. It was most necessary to lay down a percentage. More than a certain number of officers in the department should not be allowed to go in for the examination. He did not agree that for the purpose of seconding it would not be necessary to lay down any proportion at all and that Government could watch the experiment and see the extent to which the formation of a more or less purely civil medical service would lead to the elimination of Europeans. The profession in Great Britain did not trust the Government out here. This proportion must be laid down clearly and definitely; if it was desired to recruit the best men. They would then know what their chances were. This matter could not be left to the discretion of the Indian Government. He preferred to have a definite percentage fixed in the military medical service, which could be seconded for civil employ. This would secure an adequate number of British officers and at the same time the Indians would feel that they were having an absolutely fair chance.

22 February 1919.]

Dr. B. T. HOLLAND.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

(General Giffard.) The dangers that Indians might be seconded would have to be guarded against by laying down a percentage in both the services.

(President.) The Indians would undoubtedly go in much more for the civil than for military and this danger would have to be guarded against.

(General Hendley.) Military rank ought to be given to officers of the civil medical service in whatever way they are recruited. This would make the service attractive as everybody liked to have a rank as this would give the man a standing in India and the difficulty of giving rank to purely civil officers could be got over by giving them commissions in the army reserve, like the territorials at Home. They should have rank in the civil in the same way as the territorials. They would be something like the territorial medical officers.

General Cree suggested the formation of a medical branch of the Indian Army Reserve of Officers and suggested that all the men in the civil service of the country (who are not seconded Royal Army Medical Corps or Indian Medical Service officers) should be converted into the medical branch of the Indian Army Reserve of Officers. This would confer military rank on them and would enhance their status.

The witness considered that a sufficiently large number of persons would be forthcoming to join the civil branch of the Indian Army Reserve of Officers. This would also get over the question of rank. In reply to General Hendley, General Cree explained that he would leave the question as to how far the rank should go to the military authorities.

(General Giffard.) The crux of the whole question was the fixing of the proportion between Indians and Europeans.

(General Hendley.) There was a very great difficulty in getting Indians to serve in the outlying parts. There would however be no difficulty if they were ordered to do so.

Every scholarship holder in the medical schools and colleges should be compelled to go up for military duty if necessary. It would then be possible to form a reserve of assistant surgeons who would be called upon to take up military duty in case of necessity. Great difficulty had been experienced in the war in getting men to proceed on military duty. In Sind at a meeting where a large number of assistant surgeons were present there was not one who had volunteered for this purpose although most of them were scholarship holders. But if it were made a *sine qua non* for those who got a scholarship that they would have to serve the military if required it would be possible to get the reserve. He would extend this to all graduates as well as to all sub-assistant surgeons. In short he was of opinion that all who received any kind of monetary help from Government in the way of scholarships should be at the disposal of Government for service in the military reserve.

In Baluchistan and other frontier tracts the trouble was that only military sub-assistant surgeons were employed and when the war broke out all of them were taken away. Baluchistan had to depend on the Punjab for the staff. He had suggested to the Inspector-General of Civil Hospitals, Baluchistan, a scheme for the grant of scholarships to men who would serve in Baluchistan.

The missionaries would like the idea of civil medical officers joining the Indian Army Reserve of Officers suggested by him, and they would allow their medical men to have some military training. There was no doubt some difficulty at the beginning of the war on account of the missionaries not allowing their men to join the reserve, but that was due to the fact that there was a great deal of work in India and it was desirable that the hospitals should be kept going. The reluctance was not in any way due to their disinclination to send

men on military duty. He was sure that if the missions were approached they would approve the idea.

Private practitioners, both Indian and European, should form part of this reserve. The number of European doctors was confined to the big cities, but in Upper India there were practically no private European doctors. The few that there were were in the hill stations.

(President.) He admitted that there was a great dearth of medical men at home and probably for a long time to come the number of British private practitioners in India would not increase.

(General Hendley.) Private practitioners would not be inclined to leave private practice. In the suggestion he had made about the reserve he intended that Indian private practitioners should also form part of it. He was aware that they had not come forward in this war to any extent. They might be inclined to come forward in the future as they would normally be expected to be employed in civil work in place of men who had been taken away for military duty.

The Indian Medical Service had so far met all the medical needs of the country and all that was wanted was an increase in their personnel. He was, however, in favour of a separate civil medical service, and he thought that was a better system from the point of view of obtaining recruits in Europe.

(General Hehir.) A certain number of the doctors belonging to the missions went on military duty. These doctors could safely be treated as a war reserve for future requirements. These men could not, however, be spared for routine military training for any long period but if they were required for say a fortnight the missions would probably allow that.

These doctors were satisfied with the conditions of service during the war.

The relations between the Mission and the Government hospitals were amicable and they went on happily together and there was only good natured rivalry between them. Nothing further in the direction of co-operation between them was called for.

Compared with the mission hospitals the civil Government hospitals were better staffed so far as the subordinate staff was concerned as very few of them had less than one sub-assistant surgeon.

The missionary lady doctors were of the greatest help in times of stress and did very useful service in the influenza epidemic. Their time was fully occupied and they should not normally be expected to take any extra work. They could be relied upon to take the place of Government civil doctors in future wars as they had done in this war.

To be noted specially.—Men experienced in the profession had often to leave their place to fill up some administrative post or had to join the military in order to get promotion. This was a great drawback especially in the case of specialists. After having attained a good practice and making a name in the profession they had often to give up the post in order to get promotion. If they could get their military rank and promotion without taking up an administrative post Government would get much better return for the salaries paid to them. Under the existing practice, however, an experienced person was posted to do administrative work and inexperienced persons came and took his place.

(General Giffard.) It might affect recruitment if all the sub-assistant surgeons were compelled to take up military training, but if it were made a condition that all those who were granted a scholarship should do so the desired object would be attained.

Under scheme A which created two services he did not think that the civil side would be inferior especially if the members of that service were given equal rank and promotion. It would be invidious to make a distinction in that respect.

24 February 1919.]

Civil Assistant Surgeon B. N. VIYAS.

*(The schemes and questions referred to by witnesses are contained in Volume III.)***At Lucknow, Monday, 24th February 1919.****PRESENT :**S. R. HIGNELL, Esq., C.I.E., I.C.S. (*Presiding*).

MAJOR-GENERAL G. CREE, C.B., C.M.G., A.M.S.

MAJOR-GENERAL P. HEHIR, C.B., C.M.G., C.I.E., I.M.S.

MAJOR-GENERAL H. HENDLEY, K.H.S., I.M.S.

THE HON'BLE MAJOR-GENERAL G. G. GIFFARD, C.S.I., I.M.S.

LIEUTENANT-COLONEL A. SHAIRP, C.M.G., Indian Army.

MAJOR M. T. CRAMER-ROBERTS, D.S.O., Indian Army.

MAJOR A. A. MCNEIGHT, I.M.S., (*Secretary*).

DR. B. N. VIYAS, Rai Bahadur, Lucknow

Written statement.*Answers to questions for witnesses.*

I have no personal knowledge as regards the first three questions, but I have read through the attached schemes. All of them appear to me to be for the benefit and extension of the military service at the expense of the civil. I have therefore ventured to submit a scheme and have confined myself chiefly to the questions which fall within my personal experience.

4. I have no personal knowledge as to what has been the result of withdrawing European medical officers from charge of troops, but I can speak with personal experience as regards districts and jails. All the districts I served in as civil surgeon since the outbreak of the war were previously held by European Indian Medical Service officers. I have been touring throughout the provinces for the last two years and have come in contact with practically all the medical officers in charge of the districts. Except in a very few instances I can not say that the medical work of a district has in any way deteriorated on account of the withdrawal of Indian Medical Service officers. The head of the department has declared in his annual report and his budget speeches that the work of the province on the whole continued to be fairly well done and that the professional work has continued to develop. There has been some complaint about the medico-legal work. But that was, I think, due, not to the absence of the Indian Medical Service officers, but to the unreasonable distrust and suspicion with which the district officer looked upon the work of a temporary and officiating medical officer. These latter officers lacked that support and sympathy which officers ordinarily extend to one another. Mistakes that were due to want of experience and diffidence were ascribed sometimes to worse causes. Lack of efficiency in jail administration, which was sometimes complained of, was also due to similar causes. It cannot be expected that an assistant surgeon who has never been given the charge of a jail, should make as competent a Superintendent as an Indian Medical Service officer who, by virtue of his being a civil surgeon also, is a superintendent of a jail. I am certain that on the whole the medical and the jail work of the province which, except in cases of few large towns, has been done by the officers of the provincial medical services, was creditably done. This, as I have already said, has been testified by the head of the department.

5. The scheme that I have submitted, will, I believe, meet very well the needs of the civil administration. It would, of course, be affected to some extent by needs occasioned by war on a large scale. But it has been proved by experience during the present war that this province can surrender a large portion of its medical staff without suffering to any great extent in its medical work.

6. The scheme which I have recommended, will give both sufficient and efficient war reserve for military purpose. If such a scheme or one on similar lines,

were adopted, practically the entire civil and military services employed by the local government would form a war reserve.

7. I consider it very necessary that the medical service reserve for war should be previously trained in military work. I understand that some of the young medical men who volunteered for war service failed to give satisfaction on account of their want of experience and training. If all these temporary officers had had some previous war training, the result would have been much more satisfactory.

8. I can give no opinion whether the Indian Medical Service reserve proved of value in the present war. A very large percentage of reserve officers was surrendered from this province, they ought to have proved effective and of value.

9. I have already outlined in the scheme I have submitted, the method of recruitment for the civil medical service. The only suggestion I have to make with regard to the recruitment for the military services is that recruitment should be by open competitive examination held simultaneously both in England and in India; that 50 per cent. be recruited in England and 50 per cent. in India. Any necessary increase in the cadre consequent on proposed reorganization and unification of services should be met mainly from among the temporary Indian Medical Service officers now serving in the Army.

10. I have no suggestion to make as to grant of special leave for study or as to prescribing periods of study. Medical officers other than those of the Indian Medical Service, should be given equal facilities in these respects.

11. I think that a special department of research should be instituted. But the directors of research institutes should not necessarily be selected from among those in the military service. Best available men should be obtained and sufficient emoluments should be offered to attract them. Besides selected officers deputed to the department for research work, passed students from the Indian Universities showing special aptitude for research work should be selected for such work and they should be given adequate scholarships for the period of their deputation.

12. Private practice in small districts has decreased in the case of Indian Medical Service officers, as well as in the case of other medical men in service, but it never was much in these districts. In large cities there is no reason to think that practice has declined; if it had, these charges would not be sought for as they are now. There are larger number of private practitioners in larger towns than before, but they contribute to the private practice of a civil surgeon by seeking consultations with him.

Answers to questions relating to Medical Stores Department.

1. Stocks of drugs and instruments for district board hospitals and dispensaries are obtained from selected

24 February 1919.]

Civil Assistant Surgeon B. N. VIJAS.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

firms in India and England both for the purpose of the annual and emergent indents, but these firms must be recognized by Government as of good standing.

2. Responsibility for indenting rests with civil surgeons in the case of district board hospitals and dispensaries. Indents on the Medical Stores Department for Government hospitals, jails, etc., are countersigned by the Inspector-General of Civil Hospitals. In my opinion the present arrangements should continue. If the Government Medical Stores Department were made the sole source of supply, it would seriously interfere with the dealings of large firms in India which trade in drugs and instruments. My personal experience is that hospitals which obtain their supplies in the open market get a better quality of instruments and necessities than those which obtain their supplies from the Medical Stores Department.

3. I have no personal experience with the working of the Medical Stores Department.

SCHEME.

Having absolutely no experience of military service, I do not consider myself competent to give any opinion on questions relating purely to that department. In order to be able to touch on the points which fall within my experience, I would briefly outline a scheme, confining myself chiefly to the suggestions regarding the reorganization of the civil element of the proposed unified service.

The employment of the military medical services for the civil needs of the country dates practically from the commencement of the British rule in India, they have consequently so adapted themselves for the purpose that it has come to be recognized as a necessity. By itself the employment of the military medical services for civil needs has no justification. But the western system of medicine was practically introduced in this country by the military doctors; it is through their agency that it has developed to its present extent, so much so, that they have come to be more or less indispensable to the civil needs of the country and unless the circumstances change considerably they must partly continue to be so. In other words, much as I would like to see that the civil medical work is done by civil medical men, the necessity for the provision of a war reserve must be recognised and faced. But that does not mean that practically the whole of the superior civil medical service of the country should be absorbed by the military. If we are to adopt any of the proposed schemes entirely, this would surely come to pass. The public services commission laid down that should experience of the present war lead to an increase in the military reserve as would seriously endanger the maintenance of a civil element in the civil medical administration, it should be considered whether a minimum number of civil officers should not be fixed, and they also were of opinion that the civil department should not be a mere adjunct to the military service. I would, recognizing the necessity of a sufficient war reserve and also the development of the civil medical services, limit the employment of military officers to superior civil posts to 50 per cent. inclusive of higher administrative posts. The remaining 50 per cent. should be filled up by the civil medical service in the manner proposed below.

Thus the unified medical service would consist 50 per cent. of reserve military officers and 50 per cent. of civil officers, with equal status for both. The service of military assistant surgeons should in my opinion be abolished. Their position (so far as I know) in military as well as in the civil department, is anomalous; that the chief medical officer of a district should be a person who would not be allowed to practise anywhere in the United Kingdom, would not be tolerated in any other country but India; that he should have complete professional control over a person possessing admittedly superior qualification, is still more anomalous; that he makes a good administrative officer is no justification for perpetuating such an anomaly. If their qualifications are to be raised to the standard registrable in England, then both the civil

and military services would be opened to those who would otherwise be military assistant surgeons. If this service is abolished, it will set free a large number of superior civil posts, which would make it possible to maintain 50 per cent. proportion of the civil and military elements.

For the purpose of providing a further war reserve, the entire civil element of the service should in future be recruited on the condition that for a certain number of years from the commencement of service it would be liable for military duty, if called upon to do so. Thus the entire medical services of the country would form a war reserve. Personally I have no doubt that if the conditions of service are made reasonable and sufficiently attractive, there would be any objection from any quarter to such a provision. Liability for military service being made a condition of service, it follows that the personnel concerned should be given some previous training in the nature of the work they would be called upon to perform, for the efficient discharge of those duties. I do not consider that it would be practicable to form a war reserve from the body of private practitioners. I do not think that if the above proposal be adopted it would be necessary either; except to fill up the civil posts falling vacant by deputation of civil officers to military duty. I wish to bring to the notice of the Committee that if the strength of the military service is increased to an extent, suggested in some of the proposed schemes, the war reserve, I take it, would have to be correspondingly increased to an extent which it would be impossible to provide for in any conceivable scheme. If all the superior civil appointments in India were to be given over to the military reserve, even then a large number of reserve officers would be left unprovided. Such swamping of civil posts by the military would be inconceivable. I have therefore proposed utilization of all the available civil medical element as war reserve, and uniting the employment of military officers on civil side to 50 per cent. I see no reason as to why the civil medical officer, if trained, could not serve this purpose. If a war reserve has to be provided for, the civil and the military services will have to be interdependent.

The following is the brief outline of the scheme for recruiting the civil-medical service of a province :—

(1) That superior civil appointments of the province should be filled by half civil and half military officers.

(2) That higher civil administrative posts should, for the present, be reserved for members of the military services.

(3) That, with the above exception, the status of civil and military officers should be equal and no distinction should be made between them. Both should be placed in one provincial cadre.

(4) That military officers deputed to civil department should at least have five years' service.

(5) That seniority should count from the date an officer has joined the superior service whether he be military or civil.

(6) That when a military officer has once been deputed to the civil, he should be under the orders of local government except for military purposes.

(7) That the entire civil element of the service should consist of two grades—one junior and the other senior. The senior merging into the superior unified service and the junior replacing that which is known as assistant surgeon's service.

(8) That qualifications for entrance to the service be registrable by the medical council of England.

(9) That successful candidates belonging to a particular province, should be given a preferential claim to appointments in their own province, and once so appointed their names should be brought on the provincial cadre for the rest of their service.

(10) That central authority for the above purpose should be placed in the hands of the Director General or an officer corresponding to him appointed after the proposed reorganization.

(11) That the admission of the requisite number of candidates to the civil medical service of the province

24 February 1919.]

Civil Assistant Surgeon B. N. VIJAS.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

should be by open competitive examinations for the whole of India irrespective of caste, creed and colour, to be held by a body to be hereafter determined.

(12) That the successful candidates should be appointed to the junior grade of civil medical service. These shall hold the same posts as are held by civil assistant surgeons.

(13) That the title of assistant surgeon be dropped and an officer should be given the courtesy title of doctor and known by the post he may happen to hold.

(14) That after 10 years' service he should be promoted to the senior grade if found fit in all respects.

(15) That those members of the junior grade who have acquired higher professional degrees during 10 years should have preferential claim to promotion to the senior branch provided they are otherwise fit.

(16) That the members of the junior grade should be given facilities to go to England to broaden their outlook and acquire higher degrees.

Replies to questions for civil assistant surgeons.

1. I am prepared to serve with Indian troops and in station hospitals provided I am given, during my deputation to the military department, a commissioned rank and pay corresponding to my seniority in my service.

2. I am not satisfied with our existing pension rules. Medical men have to lead a strenuous life. Assistant surgeon's is a hard worked service, if the pension rules are modified so as to allow an officer to retire on full pension after 25 years' service and on an invalid pension after 20 years' service, the concession will be greatly appreciated.

3. I have no personal knowledge relating to this question.

4. Number of disabilities exist in the department, which I consider should be brought to the notice of the Committee. The first and the foremost of these is the doubtful status of a civil assistant surgeon. While he is shown as a gazetted officer, he is seldom treated as such. Considerations due to a gazetted officer are seldom extended to him. In public assemblage such as Durbar he is relegated to a position according to his pay and not according to his education and rank. He is not exempted from the Arms Act as the majority of gazetted officers are. Quarters with which he is supplied, except in a few instances, are insufficient and uncomfortable. He is not allowed facilities, such as study leave, accelerated promotion, etc. He is still required to pass two septennial examinations, which were instituted when the educational standard was not sufficiently high and facilities for keeping professional knowledge up to date did not exist. With the present day education and facilities for keeping one's knowledge fresh these examinations are unnecessary. It is not clear from the question whether I am required to suggest remedies for the disabilities mentioned above, but I venture to mention them briefly. His status as gazetted officer should be clearly defined. The service to which he belongs should not be treated as a subordinate service. The appellation of "civil assistant surgeon" should be dropped. The courtesy title of "Doctor" should be given to him and he should be known by the appointment he happens to hold at the time. He should be exempted from the Arms Act like other gazetted officers. He should be provided with comfortable and respectable quarters. He should be allowed study leave to enable him to improve his knowledge and qualifications. Septennial examinations should be abolished. Assistant surgeons are not given the facilities to improve their operative work, in most of the districts in charge of Indian Medical Service officers it has been the rule, rather than the exception, that all important operative work should be done by the civil surgeon himself. I strongly think that assistant surgeons should have equal share of the operative work.

5. Civil assistant surgeon's service is beginning to lose its attraction for the best class of young men. It is amply illustrated by the fact that in recent years able men have resigned in favour of private practice. While other services have considerably

improved, or are improving, with the exception of few grudging concessions given at long intervals, the assistant surgeon's service practically remains where it was 20 years ago. In Calcutta and Bombay the best qualified men, so far as I know, do not care to enter the provincial service, same tendency is beginning in this province.

6. My suggestions with regard to the question of recruitment are given in the scheme which I have submitted.

7. The appointment of military assistant surgeons to a larger number of civil appointments would not only be unpopular, but would be strongly resented. It would adversely affect the provincial service. Before the commencement of the war, a larger number of civil surgeoncies was held by military assistant surgeons than by the members of the provincial service, they were given better status, posts carrying large practice such as assistants to the civil surgeons of Allahabad, Naini Tal, Mussoorie, are reserved for them, as a rule the tendency is to treat the military assistant surgeons when in competition with the provincial service, as the favourite son.

8. Provided his prospects are sufficiently improved to be reasonably attractive, and he is given a commissioned rank, there is no reason why military training and employment in case of war should not be popular. Fifty-three assistant surgeons (both temporary and permanent) and 11 health officers volunteered from these provinces for war service. These figures speak for themselves. I do not think that the giving of military training and probable employment in case of war are likely to affect recruitment for the service in any way.

Answers to questions to be asked of officers regarding assistant surgeons and sub-assistant surgeons.

1. Civil sub-assistant surgeons.—The bond prescribed in this province makes civil sub-assistant surgeons liable for civil and military duty anywhere in India, for the period of 5 years of their service, under a monetary penalty of Rs. 400. No alterations have been made during the war. The conditions of bond, so far as I know, were enforced in the majority of instances in which civil sub-assistant surgeons refused to proceed to military duty in India. I am of opinion that the period of liability for military service should be extended to ten years as I have recommended in the case of civil medical officers. Heavier monetary penalty than that in force at present might seriously affect recruiting.

2. If the period of liability for military service is extended to ten years, there would be no necessity of renewing the bond.

3. The conditions of service of civil sub-assistant surgeons are on the whole satisfactory. The local government I believe is considering the question of raising their pay and it is likely to be increased in the near future. Sub-assistant surgeons have been asking to raise their educational standard to the L.M.S. Diploma with a 5 years' course. I consider this a reasonable and legitimate aspiration. This question is also under the consideration of the Government and there is every hope of its being carried out.

4. Civil assistant surgeons and sub-assistant surgeons.—I have ascertained that 53 assistant surgeons, temporary and permanent, and 150 sub-assistant surgeons, were supplied from this province. I think 25 per cent. to 33 per cent. could be spared without serious dislocation of work. The cadre of sub-assistant surgeons is constantly increasing and in future the number that could be spared would no doubt be increased.

There was, I believe, a certain amount of dislocation from deputing these men for military duty, but it was met by employing temporary men in place of assistant surgeons and compounders and private practitioners in place of sub-assistant surgeons.

5. Civil Assistant Surgeons.—I have already said in reply to a similar question elsewhere that liability for military duty should be a condition of service for the civil medical officer provided his prospects are rendered

24 February 1919.]

Civil Assistant Surgeon B. N. VIYAS.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

reasonably attractive and he is given a commissioned rank during his deputation to military duty. Time limit should be ten years from the commencement of service.

6. The medical requirements of the general population and the State are satisfactory so far as they go. With the gradual spread of the western system of medicine there is bound to be a corresponding increase in hospitals and dispensaries. There are enormous possibilities in this direction. The Government is doing what it can. The public charities might with advantage be directed towards the establishment of children's hospitals in some of the large towns of the province. The present system of control and supervision appears to me to be quite efficient, and no change is desirable in that direction. The only point which I should like to emphasise in this connection is the undesirability of subjecting medical services to immediate lay control.

7. Military Sub-Assistant Surgeons.—I do not exactly know what the station hospital system is, but sub-assistant surgeons in some of the larger civil hospitals occupy a varying role; in some he is employed as a house surgeon and house physician, in others he looks after the out-patients. I think he can adequately fill the place of a resident medical officer. In the Thomason Hospital, Agra, three passed students are annually appointed as house surgeon, house physician and house surgeon in the Eye Hospital. So far as I know no complaint as to their unfitness for these positions has ever arisen. I do not know what sort of work he will be called upon to do outside the hospital.

8. I was a lecturer in the Agra Medical School for about seven years and know the training he receives. I think it is as good as can be desired for medical men of his standing. Military hygiene might with advantage be added to the curriculum. I would strongly suggest the establishment of a central medical school

exclusively for military sub-assistant surgeons. The Agra Medical School, which is the largest in India, could, with great advantage, be utilized for such a purpose as the establishment of another school for civil sub-assistant surgeons in this province is under the consideration of the Government.

9. I am not in position to answer this question.

10. Assistant Surgeons and Sub-Assistant Surgeons.—I am not in position to answer this question.

11. Sub-Assistant Surgeons.—All that I have to say with regard to this question is given in my answer to Question No. 3. If it refers to military sub-assistant surgeons, I would recommend his starting his service with an Indian commissioned rank.

12. Military Assistant Surgeons.—I have no personal knowledge of the points raised in this question.

13. I do not know to what extent he relieved the demand for medical men in military department. Very few military assistant surgeons are available for employment on the civil side.

14. If a military assistant surgeon is not needed for work in British military hospitals, I do not think there is any other field of employment for a medical man with his qualifications.

15. I have recommended the abolition of military assistant surgeons in the scheme I have submitted. No further recruitment of his class should take place.

16 and 17. If the educational standard of the military assistant surgeon is so raised that he can obtain a qualification registrable in England, in all probability he would not be satisfied with his subordinate position in the military department. With the registrable qualification he could, and would, want to compete for the commissioned Army Military Service. The civil medical department would also be open to him for competition.

18. I have no suggestion to make in this respect.

DR. VIYAS, called and examined.

(Mr. Hignell.) He was in favour of having one unified superior service both for civil and military purposes.

If it were decided to have a more or less separate military and civil medical service, he would organise the civil service on the basis of a large Imperial service with the necessary provincial organization, rather than on the basis of a small Imperial service on which would hang the provincial organizations. The provincial governments should have power to appoint their own men to that service. The service should be recruited on an Imperial basis and the men belonging to a particular province should be given preference for appointments in that province.

(General Cree.) Assuming that there was a separate civil and military service it would meet the aspirations of Indian practitioners as regards the military if the examinations were held simultaneously in England and in India and a definite proportion fixed for the examination held in India.

If, under scheme 'A' the auxiliary corps would have the same social status, the same pay, promotion, rank, etc., as the Royal Army Medical Corps, with the only difference that the members of the former would be confined to service in India, the scheme would meet with the aspirations of Indians. If, however, the War Office or the Government of India decided that, though normally this Indian section of the Royal Army Medical Corps should only do duty in India and wherever the Indian Army goes, yet it would retain the right to send its members all over the Empire, this would to a certain extent deter Indians from joining the auxiliary corps.

(General Giffard.) He had not thought over the difficulties which might occur if simultaneous examinations were held in England and in India but he did not consider that they would be insuperable. One of the difficulties would be that if the same papers were set for both the examinations and the examinations were held on the same date the papers would be out in India seven hours before they would be out in England but this should not stand in the way of simultaneous examinations. There might be two sets of papers by

the same examiners for England and India and the same standard could be secured by the examiners being the same.

He agreed to the auxiliary corps suggested in scheme 'A' on the understanding that it was to be regarded as in no way inferior to the Royal Army Medical Corps. The fact that the members of one would have to serve in all parts of the Empire and that the members of the other would be confined to service in India should not be allowed to affect the position. The underlying idea was that the status should be the same but the liability to serve should be different.

(General Hendley.) He did not see a practicable way of utilizing private practitioners as a war reserve, except to fill civil vacancies caused by officers being given up to military duty. So far as he was aware no experienced private practitioners had volunteered for military duty. The reason for this was that their practice would suffer severely.

He had said in his written statement that 53 assistant surgeons in the United Provinces had volunteered for military duty. Probably the largest proportion of them was fresh from college, and the number of experienced practitioners was really insignificant. It was very unlikely that experienced practitioners would come forward willingly for military service.

He had suggested in his written statement that members of the junior grade should be given facilities to go to England to broaden their outlook and to acquire higher degrees. He did not mean to suggest thereby that Government should assist them financially.

By the remark, in his written statement, as to the undesirability of subjecting medical services to immediate lay control, he referred to the proposal made in the United Provinces in connexion with the extension of local self-government, to the effect that assistant surgeons should be placed under the control of the district boards. He was very much opposed to this proposal and was strongly of opinion that it would be impossible to work a system of that kind.

24 February 1919.]

Major J. W. D. MEGAW.

(The schemes and questions referred to by witnesses are contained in Volume III.)

MAJOR J. W. D. MEGAW, M.B., I.M.S., Principal, King George's Medical College, Lucknow.

Written statement.

I consider that scheme 'A' is put out of court owing to its insisting that the Royal Army Medical Corps should constitute the unified medical service for India.

The fact that Indians and Anglo-Indians are ineligible for service in the Royal Army Medical Corps makes such a scheme inconceivable.

In many respects I agree with schemes 'B,' 'C,' and 'D,' but I think that the best solution of the problem lies in a really unified medical service for India such as I attempt to outline.

There are many practical difficulties in establishing such a unified medical service, but I think that these should be deliberately faced. It is unlikely that such an opportunity as the present will again be presented for instituting an efficient, economical and satisfactory medical service.

The advantages of a truly unified medical service, such as I suggest will be—

I. It will meet the requirements of the army in India more efficiently than any dual service.

For example in each large station there would be one central hospital with separate provision for Indian and European troops.

This hospital would be under the control of one administrative medical officer, there would be one staff of medical officers for the hospital, several of these would be specialists in such subjects as Surgery, Medicine, Ophthalmology, Venereal Diseases, Pathology, Radiology, etc. Each specialist would require only one set of equipment and one staff of attendants. There would be one nursing staff, one menial staff, one dispensary, one supplies department and altogether the hospital would be one large unit, which could be maintained at a far higher pitch of efficiency and economy than is possible with two separate units.

II. In such a scheme Indian Medical Service officers could easily be incorporated. At first the British soldiers would probably object to being looked after by Indian doctors, and in fact it would probably be injudicious to employ Indian medical officers in the European wards at the outset. But the British soldier when he finds that the Indian medical officers are doing the same work as the European and that some of them are skilled experts in certain branches would gradually lose his prejudice just as the European and Eurasian in civil life have taken to consulting Indian doctors in a steadily increasing degree.

The Indian officer would have much greater opportunities of identifying himself with the corps to which he belongs and through the experience that he would gain in dealing with Europeans he would become much more suitable for filling civil posts in which he would be the doctor of European officials and their families.

III. In such a service with co-ordination between the civil and military departments there would be much greater scope for men of varied talents and so it would be easier to place the right man in the right place.

IV. Junior officers would have great opportunities of improving their professional knowledge as they would be members of a large staff containing experts in the various subjects and these experts would have a much large amount of material at their disposal than with the dual system, professorial enthusiasm and comradeship would be fostered and the existing jealousies between the two services would disappear.

V. Members of such a corps, instead of gradually becoming stale in their professional work would be likely to improve greatly in professional knowledge and so would be better equipped for doing civil work when opportunity offered, at the same time the prospects of doing medical work and of obtaining responsible charges on the military side would be such that a failure to obtain civil employment would not be regarded as a great hardship.

VI. Taking everything into consideration the Indian members of such a service would be as well, or better off than the Europeans for they would be members of a well paid service in their own country and the initial drawbacks of having to adopt themselves to new social conditions would only be felt at the beginning of their service. As members of a medical mess they would have much more in common with their European colleagues than as medical officers of a regiment.

VII. Transfers would be far less frequent.

RECRUITING FOR THE UNIFIED SERVICE.

A. Initial Recruitment.

To begin with it would be desirable to incorporate a certain number of the best officers of the Royal Army Medical Corps. Favourable terms should be offered to induce these to join the unified service, but these terms would have to be carefully drawn up so as to avoid any prejudice to the prospects of members of the Indian Medical Service.

During the war promotion in the Royal Army Medical Corps has been so rapid that large numbers of Royal Army Medical Corps officers have become senior in rank to members of the Indian Medical Service, who are their seniors in service and in most cases their superiors in professional attainments.

The Indian Medical Service has suffered very seriously in this respect through no fault of its own and it would be exceedingly unjust that this inequality of treatment should be crystallised in the new scheme.

B. Future Recruitment.

In my opinion this should be for the most part (say 80 per cent.) by competitive examination in England.

To secure the best Indian students for the service, the local governments should be induced to award post-graduate scholarships to selected students to enable them to study in England.

These students would be in a position to compete on more favourable terms than the unaided British students and even if they failed to enter the service their aided training in England would be of great value to them in their after life.

Indians have set their hearts on simultaneous examinations in India and England, but in their own interests as well as in the interests of the service there are objections to a separate examination.

Apart from the great difficulty of securing a perfectly uniform practical examination, such a system of recruitment would necessitate a separate course of training in England for the Indian members of the service while their British contemporaries would be undergoing a course of training in India.

Hence the British and Indian members of one batch would form two distinct groups for the first year or two of their service, and these two groups would not easily be blended afterwards. On account of this there would be no opportunity of promoting the feeling of unity and mutual understanding which are essential in a unified service.

At the same time the desire of Indian students for a simultaneous examination is deserving of consideration and it would facilitate the maintenance of the requisite proportion in the numbers of Indian and European members of the service.

My personal view is that while simultaneous examination has great advantages from a political standpoint, it would involve a sacrifice of the ideals of the unified medical service.

(2) By nomination of the remaining 20 per cent. of the members of the service.

This method of recruiting is intended to provide a means of securing the services of men with special

24 February 1919.]

Major J. W. D. MEGAW.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

abilities, who for some reason or other do not care to enter the service by competitive examination.

These nominations might be made partly by the Secretary of State and partly by the Government of India and they should be made purely in the interest of the service. They should, as a rule, be reserved for men who have already shown some special capacity which would indicate that they would be valuable acquisitions to the service.

Each nominee might, in the first instance, be nominated for some special post which could not be so well filled by regular members of the service, but he would be liable to transfer and to the same conditions as other members of the service.

In addition there could be a provision for the deputation of selected members of the Indian Medical Service for a tour of service with the Royal Army Medical Corps and *vice versa*.

By this means the service would be kept in touch with any moderate developments which take place in the sister service.

General Conditions of Service.

After recruitment, junior officers should have a period of training in tropical diseases and in military matters.

They should then be attached to a large military hospital for duty.

At the end of 4 or 5 years of service, those desirous of civil employment should be asked to send in their applications with a statement of their special qualifications and of their personal predilections.

From each batch a certain number should be selected by the Director General in consultation with his advisory board (referred to later).

In this way a list would be formed of men designated for employment in civil. This list should be kept of such dimensions that men would ordinarily be posted to civil somewhere between four and seven years of service, but in special cases an earlier or later transfer might be made if the advisory board considered such a transfer desirable.

Officers designated for civil employment should, in the first instance, be sent to fill leave vacancies occurring in the civil posts classed as non-essential.

In this way the officers would serve an apprenticeship in the class of post to which they would later be likely to be sent, and their suitability or otherwise for civil employment could be gauged.

The filling of leave vacancies by men in military employ would obviate to a large extent the frequent transfers that are necessary at present in the junior civil appointments.

Men in civil employment should not be posted to any special provinces but should be available for service wherever they are required. Their postings in any province would be subject to the approval of the Director of the Civil Medical Service, who would have at his disposal a large number of selected men, so that he could always find a suitable man for any particular post.

The special desires of the local governments should be duly considered in connection with any appointment, and also where possible the wishes of the medical officers concerned, but obviously the selection of an officer for a particular post could best be made by the head of the department who has a large cadre from which to select, and who at the same time can take into account any special representations of the local governments.

All postings of Indian Medical Service officers whether in civil or military employment should be under the control of the Government of India.

Such control is essential, not only in the interest of the State but also to remove one of the most serious causes of the feeling of insecurity which has of late been the greatest deterrent of recruiting for the service. In the case of a technical service like the Indian Medical Service it is essential that the work and capacity of members of the service should be estimated by experts

who would be in a position to judge not only a man's professional abilities but also the other considerations which have to be taken into account.

There might be some provision by which an officer who is found to be unsuitable by a local government might be returned to military duty.

With a system of selection such as has been described this safeguard of the interests of the local governments would probably be put into action only in rare instances.

Apart from temporary posting to leave vacancies officers should be deputed to civil employment for periods of five years each of which should, as far as possible, be spent in one appointment.

After each spell of civil employment the officer might return to military duty for a period of six months or a year.

Any officer remaining in civil employment after three such spells of five years' service in civil must renounce all claim to military appointments and he should remain permanently in civil employment unless the military authorities themselves ask for his services to be placed at their disposal for a specific post.

Officers in certain essential civil appointments should be exempted from return to military duty.

Promotion in the service to be by examination to the rank of captain and also by examination to the rank of major and lieutenant-colonel, except in the case of those specifically exempted by the advisory board on account of special qualifications such as would not readily admit of being tested by examination. Such officers as are exempted to be eligible for any accelerated promotion that would be obtainable by examination.

It would probably be found desirable to insist on examination for promotion to the rank of major and lieutenant-colonel only in the case of officers who have not proved themselves specially valuable to the service.

In addition to the regular officers of the unified medical service there should be a further reserve consisting of junior members of the provincial medical service.

These should receive allowances in return for their undertaking to do military duty when called on. They would do such periods of training in military hospitals as are considered essential. They might receive honorary military rank up to the rank of captain and have the right to wear uniform on ceremonial occasions. It is likely that all new recruits to the provincial medical services would gladly become members of the reserve of the service. Thus a very valuable reserve of officers would always be available. Independent medical practitioners might also be called on the reserve, but they will possibly not be needed and in any case they would be required as a reserve for the provincial medical officers if they were called up for military duty.

In my opinion such a unified service would not only considerably enhance the value of the Indian Army as a fighting unit, but it would also greatly promote the advance of medical science and medical education in India.

The medical services in India have had hundreds of very able officers whose talents have been frittered away because of the conditions of service. By such a scheme as the above there would be a means of utilizing and stimulating the professional ability of every officer.

The greatest difficulty in connection with this or any other scheme will be to maintain a fair proportion between the British and Indian recruits to the service. Opinions will differ widely as to what constitutes suitable proportion. If I were interested solely in the welfare of the British medical students I would advocate a clean sweep of the European element from the service.

In my opinion the hundreds of medical men who have spent the best years of their lives in India have made bad bargains and have sacrificed more than they have gained, though of course as individuals they have

24 February 1919.]

Major J. W. D. MEGAW.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

no cause for complaint as they have entered the service of their own free will.

If it is decided that the European element can be largely diminished without great sacrifice there will be no feeling of regret on my part, but from the point of view of the efficiency of the army in India and of the welfare of the country in general I am of opinion that a body of the best experts that Britain can supply is an absolute essential to Indian progress.

I am also of opinion that when these men have undertaken to serve India, they should be treated with the consideration due to trusted servants and should not be exposed to the constant insinuation that they are interlopers and adventurers who are exploring India for purely mercenary motives.

It is quite possible that India may gradually become self-supporting in the matter of medical men: this condition will only be brought about by the employment of the best men that Europe can supply. If this is done medical education will reach such a standard that students will rarely have to go to Europe even for advanced courses of training.

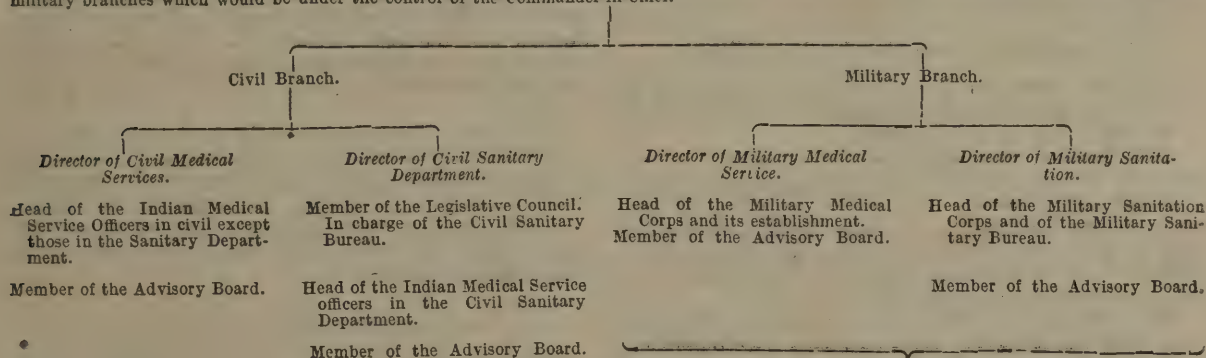
The work that has been done by Indian Medical Service officers in medical education and in research has been of enormous value to India; if this work had been carried out under more favourable conditions the results would have been correspondingly greater.

My views as to the position and duties of the heads of the unified service will be seen from the table given herewith.

SCHEME FOR GENERAL ADMINISTRATION OF THE UNIFIED SERVICE.

I.—Head of the Service.

Director General with the status of adviser to Government on medical matters as a Secretary to Government or otherwise and with direct access to the Viceroy. In charge of the special research officers and of any medical enterprises directly under the Government of India. President of the Advisory Board which will deal with transfers from military to civil and *vice versa* and with such matters as may be referred to the Government. He would serve to co-ordinate the various branches of the service, but would not interfere with the internal economy of the military branches which would be under the control of the Commander-in-Chief.



Both of these officers would be members of the General Staff and would be directly under the orders of the Commander-in-Chief. As members of the Advisory Board they would help in the co-ordination of the Civil and Military Branches of the service and would have the right to express their views on matters affecting the interests of officers of the Indian Medical Service in general.

Each of the above four heads of departments might be appointed for a term of years, and it should be arranged that before taking their duties they should be specially deputed for six months to travel to Europe and America to make themselves familiar with the most recent developments in matters relating to their duties.

The most important innovations are:—

I. The Advisory Board which is intended to co-ordinate the various branches of the service, especially in the matter of transfers from one branch to another, and to advise Government on any questions regarding which authoritative technical advice is needed. Additional members might be added when special expert advice is required.

II. The Health Bureau for the army and for the civil department. Preventive medicine has not been given the position of importance that it deserves, and the formation of a Health Bureau would make it possible for all facts of importance to the health of the community to be collected and analyzed. The bureaus should be expected to issue bulletins and press communiqués when these are likely to be of benefit to the health of the army or of the people of India.

For example in the recent influenza epidemic authoritative press communiqués would have been of very great value.

III. The deputation of officers who are designated for appointment as Directors, with a view to enabling them to bring themselves up to date in matters affecting the administration of their departments is an innovation the value of which is obvious.

The Inspector-General of the medical services of each province should have the position of a Secretary or Joint Secretary to the local government with direct access to the Lieutenant-Governor and so should the Sanitary Commissioner. The latter would also be in charge of provincial Sanitary Bureau which would keep

in touch with all matters affecting the health of the province and would issue communiqués to the press when necessary.

The provincial medical and sanitary services should be retained as far as possible under the control of the local Governments. If medical officers are handed over to the control of local bodies all the advantages which will result from the formation of a well organized technical corps will be lost and the efficiency of the medical and sanitary departments will be seriously diminished.

The officers of the provincial medical and sanitary departments are already alarmed at the prospect of finding themselves handed over to the control of local bodies who have not the technical knowledge which is needed to enable them to judge of the work of their medical officers, and the unorganized individual medical officers of the province would have little value as a military reserve. Medical service in the province just as in the army must be organized if it is to be efficient and, however, strong may be the arguments in favour of entrusting other matters to local bodies, it would be a very retrograde step to hand over highly technical subjects like medical relief and sanitation to purely lay control.

There is a strong movement among medical men in England for the institution of a state medical service, it will be nothing short of a calamity if the medical services in India are disintegrated instead of being improved and reorganized.

24 February 1919.]

Major J. W. D. MEGAW.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

Finally I am of opinion that where vested interests are opposed to the adoption of a satisfactory scheme, these should be ruthlessly set aside.

Many individuals may suffer in prospects from the formation of a sound scheme; it will be much more economical for Government to compensate them liberally than to allow the protection of their interests to thwart reform.

No scheme can be a success unless it is founded on business considerations. The question is one of supply and demand and the pay and prospects of the service must be such as to attract candidates, both European and Indian of the required standard.

With existing conditions and existing prospects only those Indian and European students are likely to enter the service who see no chance of success in private practice. To recruit such men is a wicked waste of public funds. India cannot afford a service composed of indifferent or bad doctors, the whole future of Indian administration, both civil and military, depends on the possession of a first class medical service.

That such a service will be more expensive in the future than in the past is obvious, but if the present state of things is continued, the service will not be expensive in the future, it will literally be ruinous.

Replies to questions for Service Officers.

(1) Three years in military service, nearly two of which were spent on active service.

Sixteen years in civil service.

(2) I have no personal cause for complaint or discontent, Government has kept its bargain with me.

There are, however, two points to which I may refer in this connection. The first is that large number of Royal Army Medical Corps officers have been promoted to the rank of lieutenant-colonel long before my turn for promotion has come.

This promotion so far as can be judged by the available tests has not been due to superior qualifications.

It is not due to my having shirked military duty as I thrice expressed my readiness to go on active service in any capacity.

I have no ground for complaint in this respect as the men who obtain promotion and decorations have thoroughly deserved them, but there is no doubt that the present unpopularity of the Indian Medical Service is largely due to the fact that so many Indian Medical Service officers through no fault of their own have found themselves left far behind in respect to promotion and rewards by large numbers of men of junior rank and lesser professional attainments.

The second is that during the two and half years for which I have been Principal of a large hospital and of a large residential medical college with all the attendant work and responsibilities, my services have been valued at about Rs. 5 per day gross and Rs. 3 or less nett.

At such a remuneration there is not much encouragement for the best men to seek for an appointment which may fairly be considered important and responsible.

Owing to the unflinching kindness and consideration of my Inspector-General and to the loyal co-operation of my European and Indian colleagues my position has been a pleasant one, but it is not likely that men of a suitable kind will easily be found for such an appointment considering the greater emoluments of the other civil posts in the province.

(3) My relations with members of the Royal Army Medical Corps in India have always been very cordial.

On the whole, members of the Royal Army Medical Corps in India have occupied an invidious position in time of peace.

During the war members of the Indian Medical Service have occupied the invidious position for the reasons given in the reply to Question 2.

(4) The establishment of a truly unified service is the only means of neutralizing grievances and friction.

(5) See my suggestions for a unified medical service.

Special questions.

1. The demands of Europeans for European medical attendance are based on the following tangible grounds which are founded on reason:—

(a) The belief that doctors educated in India have not had an efficient training in the diseases of women and children and in practical midwifery, and that they are not familiar with the habits and customs of Europeans.

(b) The fact that Indian doctors are often different and lacking in self confidence when dealing with cases of sickness in Europeans, especially in those of high position.

They are also based on the unreasonable grounds of racial prejudice.

The difficulties caused by the above considerations are likely to become less in future; at present they are very real and very serious.

2. I have met with very few cases in which Europeans have had good grounds for dissatisfaction with the treatment received from Indian medical officers, though I have frequently heard dissatisfaction expressed.

In the King George's Hospital, European patients have often been under the sole charge of expert Indian doctors and the only expressions I have heard have been of complete satisfaction. This suggests that racial prejudice is not so important a factor as is sometimes believed.

The feeling of dissatisfaction is much more likely to be felt when patients have no alternative to treatment by an Indian doctor; it is largely based on a prejudice which is likely to be greatly diminished in the future.

3. My only experience of Indian medical officers has been in civil life. Among them there has been a steady improvement in efficiency.

Questions for witnesses.

The replies to these are embodied in the scheme which I have outlined. Some special points are dealt with in the following answers:—

1, 2 and 3. See scheme suggested.

4. I have no personal experience.

5. The scheme suggested would meet the needs of the civil administration.

6. Any scheme will be affected by war, but the one suggested by me will provide for all likely contingencies.

7. The medical service reserve should have some military training: this need not be elaborate.

The reserve ought to be present in India to such an extent as to be able to cope with all contingencies against which the military authorities consider it necessary to provide.

A reserve without previous Indian experience would be of much less value than a reserve with a knowledge of Indian conditions and diseases.

8. This is a question for persons of military experience. I think it is likely that the medical arrangements would have broken down hopelessly but for the Indian Medical Service reserve.

Colonel Balfour, C.M.G., of the Mediterranean Advisory Committee, spoke to me in glowing terms of the work done by Indian Medical Service officers in Mesopotamia during the war.

9. See scheme.

10. I think that study leave should be given as at present. I do not approve of prescribing special periods of study. Everything should be done to encourage individual initiative.

11. The present arrangements, amplified and improved as the result of experience seem to be satisfactory.

Special opportunities for research should be given freely to officers who show an aptitude for it.

Most of the best research work has been done in consequence of personal initiative. Research to order is not likely to be of such a high order, though there are many cases in which the formation of a team for the

24 February 1919.]

Major J. W. D. MEGAW.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

carrying out of a special investigation would yield results of great value.

I consider the institution of a Sanitary Bureau for both the military and the civil medical services to be of great importance as a means of improving the health of the troops and of the people in India.

Research has already resulted in the accumulation of vast masses of knowledge that have not yet been brought to bear on the lives of the people.

Diffusion of existing knowledge is fully as important as the acquisition of fresh knowledge.

12. I have seldom been in posts where private practice has been allowed.

During my short spells of duty as a civil surgeon my practice was almost entirely consultant, and I think that it is chiefly to consultant practice that Indian Medical Service officers must look in the future.

Ordinary private practice has greatly declined owing to the great increase in well qualified Indian doctors.

As a consultant the civil surgeon does not compete with the independent practitioners; he comes to their help in cases of difficulty, and so all possible sources of friction are avoided.

Questions regarding assistant surgeons and sub-assistant surgeons.

1 to 9. Can better be answered by others.

Some of the points are touched on incidentally in my general scheme.

MAJOR J. W. D. MEGAW, called and examined.

(President.) Scheme 'A' was not satisfactory, as it did not constitute both civil and military. He would prefer an unified Imperial medical service, as there would be a much larger number of officers to choose from, and it would be easier to find suitable men for particular posts.

(General Giffard.) He would advocate making all the jails, colleges, etc., entirely Imperial. The Inspectors-General of Jails and Principals of the medical colleges, should be under the Government of India and if provinces expressed a desire for a specialist, they could apply to the Government of India for their wants.

Those officers who now joined the Royal Army Medical Corps would join the Indian service, and the Royal Army Medical Corps as an organisation in India would cease to exist. You would obtain a larger number from the examinations at Home. He admitted that the service thus constituted would consist of a mixture of Europeans, Anglo-Indians and Indians and possibly British officers would not like it at first; but he proposed that British officers and soldiers would be looked after by European members of the service in the beginning, and in course of time, when Indian members of the new service proved themselves capable, he hoped that the prejudice against Indians would disappear. He had not been on active service, and had no personal knowledge of the attitude of the British soldier towards Indian medical officers.

(General Hendley.) He had no personal knowledge of Indians who were employed as officiating civil surgeons. So long as such officers were attached to hospitals, or to some large educational centre, they kept up their professional knowledge; but the tendency of an officer, whether European or Indian, if isolated, was to lose his interest in his profession.

Indian medical officers would be keen in belonging to a military reserve in future. The passed students of the Lucknow College had joined as temporary members of the Indian Medical Service to more than 50 per cent. A change had come over the ideas of such Indians.

Military rank in civil service was an attraction to Indians, as it improved their social status.

If they did away with the greater part of the Indian Medical Service reserve in civil it would undoubtedly affect recruitment in England for the Indian Medical Service as most men, like himself, entered the Indian Medical Service with the prospect of doing civil work.

10. Civil assistant surgeons and sub-assistant surgeons should only be employed in military hospitals for such periods of training as are considered necessary. If employed there as a routine their value as a real reserve would be greatly diminished. There should be a full permanent military medical staff in all the military hospitals.

11. No reply.

12 to 18. I consider the position of the military assistant surgeon to be entirely anomalous.

He has been badly trained and very badly treated. After occupying an invidious position for the greater part of his service he finds that when at last he gets one of the prizes open to him—a civil surgeoncy—he is usually imperfectly equipped for the duties of the post and his presence is naturally resented by the civil assistant surgeons.

I consider that the existing members of the service deserve every consideration, they should be amply compensated for the unpleasant position which they occupy through no fault of their own but in consequence of the bad existing system.

Recruiting for the service should be stopped at once and a special body of men should be recruited from the same class as the existing military assistant surgeon. These should be trained to be Quartermasters, etc., with the rank of non-commissioned officers and their pay and prospects should be such as to attract as good a stamp of men as is recruited at present.

(General Giffard.) With regard to his joining an absolutely purely Indian civil medical service, it would depend entirely on the conditions of service, and on the prospects. Most men would not care to join a service that would be handed over to local administrations; but they would join an Imperial service. They would readily join the present Indian Medical Service if the conditions of service were good as it is an Imperial service.

Assuming that you had three examinations for the Royal Army Medical Corps for a civil service and for a purely local military service, you would get the best men coming into the civil, and it would tend to kill the military service.

(General Hendley.) It was important that officers who came out fresh to India should at first occupy comparatively unimportant posts, as if they were sent at once to large stations they would not know enough of India to enable them to make a success of their work.

(General Giffard.) He admitted that the prospect of employment in insignificant civil stations would not attract junior English enlisted officers.

(General Hehir.) The professorships in colleges should be under the Imperial service also, that is to say, under the Government of India.

The Indian medical practitioner was not at present sufficiently trained to take up professorships in medical colleges.

He would advise that medical schools in India should be in a position to accord students a complete medical education.

He would not go so far as to say that Indian private practitioners would not be utilised to form part of the war reserve; but the medical officer in Government service was likely to be more useful than the private practitioner with regard to the needs of the war reserve. He would not favour compulsion, but if the men passing out now were given some encouragement in the way of extra payment, they would join the reserve without any compulsion at all. Private practitioners could easily be induced to form a Home reserve to take the place of officers in their province who were sent out on active service.

(General Giffard.) A civil practitioner would be only too glad to find an opportunity of entering Government service if he had not to go to war.

24 February 1919.]

Major J. W. D. MEGAW.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

(General Hehir.) He favoured the formation of a unified civil and medical service.

He advocated the admission of candidates to the extent of 80 per cent. by competitive examination, leaving 20 per cent. for admission by nomination, so that men with special qualifications may be obtained.

He thought it possible to have all military hospitals under one administration; it would probably mean the establishment of several new hospitals.

He was strongly in favour of the establishment of an advisory board for the selection of candidates for various appointments, so as to co-ordinate the different departments.

He favoured the idea of sending a certain number of officers Home, on deputation, to receive a training under the Royal Army Medical Corps. It would be somewhat similar to study leave except that they would be on duty, and would get the opportunity of learning modern developments in military organization and administrative methods.

He was disposed to abolish the military assistant surgeon, very largely in his own interest. He did not mean to abolish those already in the service, but to stop recruiting from the present time. He was decidedly of opinion that the position of the military assistant surgeon was not the right one.—To begin with, they had not received a complete course of medical training; they were not qualified men, and in the military hospitals their duties were not those of fully qualified men. There was a certain number who came into civil employment who were supposed to do the work of men more completely qualified.

In a unified service you would be able to organize the work so that a smaller number would be needed than at present.

He would be in favour of getting in one or two thousand Royal Army Medical Corps rank and file in all its sections, clerical, nursing, etc.

He thought the idea quite feasible of having an Anglo-Indian military class to form a corps of clerks, nurses and ward attendants. He had not considered mixing Indians with Anglo-Indians, but thought that that would be rather a difficult question to tackle. The main idea was that men of the military assistant surgeon class, who were not recruited as military assistant surgeons, should join a corps and be quartermasters, receiving very much the same pay and prospects as they do at present, on the basis of the Home Royal Army Medical Corps rank and file.

(General Cree.) He was in favour of combined station hospitals, that is to say, both British and Indian troops treated in the same hospital and run under one organization.

He thought that it would be rather difficult to have all the British and Indian troops treated in a civil hospital, abolishing the military hospital altogether and combining the military hospital with the civil. He thought it would be a question of distance.

He did not see why Indians should object to being treated in civil hospitals where British troops were treated. In Lucknow and elsewhere they had beds for Europeans and he had not heard of Indians objecting to come because of the presence of European patients in the hospital.

It would be utterly impossible having a number of wards in King George's Hospital handed over for British and Indian troops, because they were already overcrowded; but if they had a chance of building extensions to the hospital he would advocate separate special departments, namely, an Indian hospital at one end, and a European hospital at the other. The Indian hospital would be administered by the same staff of medical officers, whose duties would be supervised by one superintendent. He did not see any difficulty in regard to the command of such a hospital.

With regard to the suggestion of a separate civil and a separate military hospital, the military under the control of the Royal Army Medical Corps, he thought that the Royal Army Medical Corps officer knowing comparatively little about Indian conditions would not be a suitable officer to be appointed as superintendent of the hospital. The military organization must be kept separate. He could not imagine a combined military and civil hospital, of which he had had no previous experience.

(President.) He thought that, if there was a large number of military patients, and the joint hospital was in the command of a civil medical officer, there might be trouble.

(General Cree.) With regard to the suggestion of having a dozen Royal Army Medical Corps officers serving in the hospital, doing practically only military work or the alternative, performing work throughout the hospital, his feeling was that it would be very unsatisfactory indeed.

(General Giffard.) His feeling was that you must have a separate military hospital and a separate civil hospital.

MAJOR G. G. L. KERANS, D.S.O., I.M.S., D.A.D.M.S. (Mobilization), 8th (Lucknow) Division.

Written statement.

I have 18 years' total service, all of which has been spent in military employ.

I have no substantial cause of complaint in view of the impending increase in the pay of Indian Medical Service officers by 33½ per cent.

I would suggest the following improvements with a view to the neutralizing of grievances or frictions:—

- (a) The introduction of station hospital system modified as suggested below.
- (b) The Director, Medical Services, should be alternately Indian Medical Service and Royal Army Medical Corps as in case of Commander-in-Chief.
- (c) Administrative appointments in military should be divided in strength proportionate to strength of Royal Army Medical Corps and Indian Medical Service (Military.)
- (d) Specialist appointments and staff surgeoncies to be divided in proportion of strength of Royal Army Medical Corps and Indian Medical Service (Military). In large stations, e.g., Lucknow there ought to be two European staff surgeons, one Indian Medical Service and one Royal Army Medical Corps, the former for Indian Army staff officers, their

wives and families plus the wives and families of Indian Army regimental officers, if required.

A limit of ten years should be fixed for transfer from military to civil employment, and 20 years for transfer from civil to military.

The organization of the military side of the Indian Medical Service should be on the lines of the Royal Army Medical Corps, i.e., station hospital system, and an Indian Hospital Corps formed consisting of the present Army Bearer Corps, Army Hospital Corps, Hospital Store-keepers and clerks, this, I believe, is in process of being done. I would modify the station hospital system to the extent of having officers posted as medical officers of regiment and to be left as much as is possible with their regiments up to 12 years' service. I see no need for any of the proposed schemes; but consider scheme 'B' the best of them.

A medical reserve consisting of the civil side of Indian Medical Service, plus private practitioners will, I feel sure, suffice for any future military needs.

I would have only one examination for admission to the medical service to be held in England as heretofore, preferable only one for Indian Medical Service, and Royal Army Medical Corps, and then, if a fair

24 February 1919.]

Major G. G. L. KERANS.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

proportion of the top men take Indian Medical Service, the Government of India will know their conditions of service are suitable.

I am all in favour of study leave and would suggest that some of it might be taken in India at approved institutions, *e.g.*, Tropical School, Calcutta, etc.

I am all in favour of a special department for research, this might be part of a military medical college run on the lines of the Royal Army Medical College, where all officers will have to pass examinations for promotion.

I think it would be desirable for all assistant surgeons to sign an agreement to serve in the military department in case of necessity up to 20 years' service, *i.e.*, as for all civil surgeons; but I would have it the rule

that the longer a man's service the less he is liable to be called up for military duty.

The proper position of military sub-assistant surgeons under the Indian station hospital system is as resident medical officers and in sub-charge of a unit. Outside the hospital they can be in sub-charge of the wives and families of the native officers, men and followers of whatever units they are detailed to sub-charge of.

The training of military sub-assistant surgeons is, I consider, sufficient.

There is no need for civil assistant surgeons and civil sub-assistant surgeons in military hospitals ordinarily.

I consider military assistant surgeons are required for work in British military hospitals.

MAJOR G. G. L. KERANS, called and examined.

(Mr. Hignell.) He was in favour of having two separate services. He would have an Imperial civil service which would form a framework on which the whole of the provincial organization would be built up.

(General Cree.) With regard to the formation of combined station hospitals contemplated in scheme 'A' witness saw no necessity for it, nor was he disposed to raise any objections to it.

(General Hehir.) He would limit the period for an officer to go to civil to 10 years.

He would advocate civil assistant surgeons forming part of the war reserve, and for this purpose they should be made to sign a bond. In the event of assistant surgeons being called for military duty he saw no objection to private practitioners taking their place. They would in this way form a civil reserve.

He would favour the establishment of a military medical college in India somewhat on the lines of the Royal Army Medical College at Millbank. He would attach a special branch to the college for the purposes of research work.

The term sub-assistant surgeon should be done away with and some better form of appellation substituted. He suggested that they should be called warrant officers, such as jamadars, subedars, etc.

On the whole he was disposed to let things remain as they were with certain modifications and improvements which he had suggested in his written statement.

(Colonel Shairp.) He would modify the station hospital system to the extent of having officers posted as medical officers of regiments and to be left as much as is possible with their regiments up to 12 years' service. He thought this was very advisable from the point of view of the regiment, as the Indian soldier would get to know his medical officer thoroughly.

On the other hand he admitted there were objections to such a course from the point of view of medical officers, as it would mean that medical officers would at times have to remain a very long time in one station and would at times probably be discontented.

He agreed with the suggestion that it would be quite sufficient if the officers were kept with their regiments as long as they were in the station.

CAPTAIN J. L. SEN, M.C., I.M.S., Indian Station Hospital, Benares.

Written statement.

I have been eight years in military service only.

Before the war I had no complaint except the very frequent transfers as a junior officer.

After the mobilization and during field service I have noticed very obvious racial distinction made by Indian Medical Service officers reverted from the civil and the Royal Army Medical Corps officers who were on tour of duty in India. This feeling was practically absent amongst the military officers.

There are Royal Army Medical Corps officers who were in the same batch with me in Millbank and Aldershot who have got special promotions during the war. Such promotions have not been sanctioned for our service.

A limit of three years' service should be fixed before an officer is allowed to transfer from military to civil employ. After 10 years in military all officers must be automatically transferred to the civil unless the officer chooses to remain in the military or is transferred to the civil before that period.

After 20 years' continuous service in the civil no officer should be transferred to the military. But they should be available as war reserve.

The defects in the organization of the Royal Army Medical Corps in India that appear to me are as follows:—

- (a) It takes a lot of time for an average European to learn the habits and customs of Indians. Directly or indirectly the Royal Army Medical Corps officers have to deal with Indians in relation to the sanitation of the British troops. Since they come to India on a tour of duty for a limited

period of time they cannot be expected to take the same amount of interest and trouble to learn the habits and customs of the people of the land as the officers of the Indian Medical Service, who will have to spend a great part of their life with Indians either with troops or civilians.

- (b) The Royal Army Medical Corps not being a part of the general medical organization of the country does not come under one administration. Since the incidence and prevention of diseases in the army is very much dependent on the incidence and prevention of diseases amongst the general population, Royal Army Medical Corps officer cannot have the same advantage in dealing with these problems as the Indian Medical Service which has got its civil and the military side.
- (c) Very often in a small station an Indian Medical Service and also a Royal Army Medical Corps officer are required for duties which could be conveniently and economically performed by only one medical officer. The absence of an unified service and the combined station hospital system necessitates a duplication of medical officers.

The defects in the organization of the Indian Medical Service in India that appear to me are as follows:—

- (a) There is not a sufficient war or leave reserve.
- (b) The same remarks (c) as for Royal Army Medical Corps (see above).
- (c) Very frequent transfers of junior officers.

24 February 1919.]

Captain J. L. SEN.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

- (d) No special promotion during the war, the result being that the Royal Army Medical Corps officers of the same batch are holding higher ranks than the Indian Medical Service officers, in many stations.
- (e) The civil side of the Indian Medical Service loses touch with the military medical organization owing to their long severance from the military.

Scheme 'C' commends itself to me because it is a comprehensive scheme and includes every branch of the medical service in India from all aspects. It is very rational and equitable. It considers both the military and civil side of the question very thoroughly and makes both the civil and the military complementary and interdependent.

I consider that Scheme 'C' would meet with the approval of the War Office and will meet the needs of the army in India. I have got the following criticisms to make :—

- (a) Military medical organization in India should be uniform with the military medical organization of the War Office.
- (b) In para. 18 of scheme 'C' I should insert that Indians with indigenous qualifications should be eligible for competition provided that the theoretical and practical courses attended are the same as are required for registrable qualification in India.
- (c) In para. 25 I should omit the promotion examination from major to lieutenant-colonel.
- (d) The Tropical School in Calcutta with modification and amplification should be converted into an Indian Medical Corps College.

Scheme 'C' will attract a good stamp of recruits and will meet the demands of the professional opinion of England and India. But the pay and prospects must be increased to compensate for the heavy rise in the cost of living.

There has been absolutely no change as the result of withdrawing the European medical officers from the charge of troops.

I have no knowledge about civil districts and jails.

The civil side of the Indian Medical Service, during the recent war, acted as a very efficient war reserve which was available immediately on the declaration of the war.

Recruitment of officers in connection with scheme 'C' should be strictly by open competition in England amongst the qualified medical men with qualifications registrable in England. I should recommend also scholarships by open competition in India for the qualified men with the registrable qualification to enable them to proceed to England for a post-graduate study in the medical schools for a period of at least six months and then competing with the others for entrance into the medical service. These scholarships should be open only to Indians, domiciled Europeans and Anglo-Indians.

After the entrance they will have the same training as in force for the service at the present time. Immediately on their arrival to India they should be made to take a course in Tropical diseases at the Calcutta School of Tropical Medicine.

I am in favour of the Indian Medical Corps College as is suggested in scheme 'C.'

Study leave should be counted as duty and as such carry full pay. It should be made compulsory after eight years of service.

The prescribed period of study should be in the first place for at least one year. If an officer fails to pass an higher examination at the first chance he should be permitted to apply for furlough for a period which will enable him to appear for the same examination for a second time. Passing an examination should not be compulsory for the study leave. I should retain the present conditions of the study leave.

My personal knowledge of the districts in Bengal is that there is very little private practice for the officers

of the Indian Medical Service in civil employ. The reasons for decline seem to me to be the following :—

- (a) Almost in every district headquarters there are a few successful private practitioners in whom the people have got great faith.
- (b) An Indian Medical Service officer being a new comer in the station does not immediately command confidence of the people unless his fame has preceded him from the other districts as a good surgeon or a physician. Now a days the people are very exceptional to change a known physician for a new-comer unless they are convinced of his professional abilities.
- (c) The usual fee charged by an Indian Medical Service officer is much too heavy for an average Indian. The custom of the service prevents others to charge a smaller fee. The high price of living has made an average Indian very much poorer and he cannot afford to pay the high fees to an Indian Medical Service officer for common ailments.
- (d) In a district if an Indian is rich he will prefer to call a distinguished practitioner from Calcutta or other presidency towns than a local Indian Medical Service officer. For surgical cases if the condition of the patient permits they will remove the patient to a presidency town to get the operation done by the Professor of Surgery or by a distinguished surgeon of the town.

Civil assistant surgeons should sign an agreement for military service, in case of necessity, any time during the first 10 years of their service.

In an Indian station hospital the senior sub-assistant surgeon will be in sub-charge and will be directly responsible to the officer commanding for the maintenance of discipline amongst the patients and the hospital personnel; and also for the feeding, clothing, and cleanliness of the hospital and the compounds, keeping the hospital records, and the correct submission of the reports and returns. He will fill the place of the resident medical officer and treat urgent cases till the arrival of the medical officer. He should be a whole-time man and will be employed outside the hospital only to look after the sick in family quarters.

The training of military sub-assistant surgeons is not suitable for military purposes. I recommend that they should get a training in the elements of Bacteriology, chemical examinations, both chemical and microscopical, and general and field sanitation. After qualifying they should be made to work as a supernumerary house surgeon or house physician in a medical school for at least six months.

The average military sub-assistant surgeon was far superior to the average civil sub-assistant surgeon as regards military work during the recent war. But professionally the civil sub-assistant surgeons were very much better in almost every branch of the profession.

The civil assistant surgeons can only be employed in the military hospital as part of their training when they join the special reserve. This period should be limited to three months after every five years. They cannot be utilised for the medical relief.

The civil sub-assistant surgeons can be utilised for the requirements of the medical relief and they can be employed ordinarily in the same capacity as the military sub-assistant surgeons.

The military sub-assistant surgeons after approval must be given the rank of Jamar from the very beginning. As they are promoted they will get higher rank in the Indian commissioned grades.

At present the sub-assistant surgeons are very discontented on account of the low scale of pay and the very frequent transfers. Their pay and prospect should be increased to make the service attractive and also if possible they should be kept in a station for a tolerably long time.

24 February 1919.]

Captain J. L. SEN.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

In civil, sub-assistant surgeons after 20 years of total service are given the rank of assistant surgeon with all the concessions by selection for ability and

merit. I recommend that the same promotion be sanctioned for military sub-assistant surgeons.

CAPTAIN J. L. SEN, called and examined.

(*President.*) He was stationed at Benares and had been there for the past six months. He had had no civil experience, but had had eight years of military service. He was in favour of scheme 'C' which contemplated two more or less separate services, civil and military. He thought they were both good, because one was complementary to the other. They were meeting different needs, military and civil, and he would keep a very close bond of union between them.

He would not lay down any proportion as to the number of Indians admissible for the two services, military or civil. Let Indians and Europeans compete on equal terms. He would not give preference to anyone, either European or Indian, but would get the best men.

(*General Giffard.*) He did not consider that it was a handicap to Indians to have to go Home in order to enter the service. From the pecuniary point of view, it was difficult for the poor man; but if a man wanted to go, he thought there would be no difficulty in his doing so, as there were so many scholarships open to Indian students. He was in favour of scholarships. He did not think it a hardship for a student going to England at his own expense to compete with a scholar subsidised by Government. He approved of the suggestion that scholarships should be repayable by the holder, as a matter of self-respect.

He had met with Indian Medical Service officers, reverted from the civil, who had made racial distinctions between Europeans and Indians.

The State gained by a separate civil and military, because the civil formed a war reserve for the military. He would train the civil to military duties for the war reserve.

(*General Hendley.*) His main idea in entering the Indian Medical Service was for the professional work the civil side afforded. That was the main idea with all Indians entering the service. If Indians had the choice, they would go straight into the civil service rather than go through the military. Military rank was an attraction to very few Indians. He could not say why more Indians in the past were to be found in the military than in the civil.

(*General Hekir.*) He approved of the suggestion to combine British and Indian hospitals and put them

under one organisation. Royal Army Medical Corps and Indian Medical Service officers would not necessarily work together in the same hospital, but if there were a unified service they would often have to do so. From his experience of service in the field, he thought there would be no difficulty in Indian officers looking after British soldiers. He did not think there would be any difficulty in peace time either as the officer commanding could enforce discipline. Eventually, when an Indian reached the position of a commandant, there should be no difficulty either.

He had had a certain amount to do with British soldiers in Mesopotamia. Before the war he had had dealings with the families of British officers and had experienced no difficulty.

With regard to the grievance he complained of, namely, that Royal Army Medical Corps officers were promoted during the war while Indian Medical Service officers were not, he cited his own case, where an officer of the Royal Army Medical Corps special reserve who had been in training with him at Aldershot, was promoted to major, while he remained a captain.

With regard to his suggestion for a school of tropical medicine in Calcutta, he admitted that the climate was bad to bring young British officers to, but the place was a suitable one for the material it afforded for research work.

On the whole he preferred the present services to continue much as they were now, namely, the Royal Army Medical Corps and the Indian Medical Service, with the modifications suggested in scheme 'C.'

(*General Cree.*) He thought that an auxiliary corps, such as that suggested in scheme 'A,' would be looked down upon.

If the Royal Army Medical Corps opened their ranks to British subjects, very few Indians would enter it, if they were liable for service in any part of the Empire.

(*General Giffard.*) He knew of two Indians who went straight from India and entered the service by examination, without receiving a training in England; and they had made quite a success in their work.

(*Major Cramer-Roberts.*) He had some Australian soldiers employed in the Wireless Section under him for medical treatment in Mesopotamia. He did not remember having any difficulty with them.

Second Class Senior Military Sub-Assistant Surgeon ABDUL GAFOOR, Allahabad, called and examined.

(*Mr. Hignell.*) The witness had put in 23 years' service and had served in the United Provinces and the North-West Frontier Province. During the recent war he had served in Egypt and East Africa. If India were not his home he would prefer East Africa.

(*General Giffard.*) The designation "Sub-Assistant surgeon" was not a suitable one and should be changed to that of Indian medical officer, corresponding to the title "Indian officer" for the combatant ranks.

The first improvement which was called for in the case of sub-assistant surgeons was that of preliminary education before joining the medical school. They should at least study up to the matriculation standard before joining the medical school. The course in the medical school should be increased from four to five years. They should get a degree like the assistant surgeons. The distinction between the assistant surgeons and sub-assistant surgeons should be abolished by the absorption of the latter in the former class. The sub-assistant surgeons should be better educated and have a better status. This would not be very expensive to Government.

There should be no distinction between the civil and military sub-assistant surgeons and they should all be military like the Indian Medical Service. The

rank of jemadar should be given from the very beginning, that is from the time a man left the medical school.

With regard to the pension rules, he said that he considered thirty years too long a period for a man to have to serve to earn the pension, as Indians got old at 55. The period for retirement should be reduced from 30 to 25, and from 25 years to 20 in the case of retirement on medical certificate.

The widows and children of military sub-assistant surgeons were badly off. This could be remedied by allowing the military sub-assistant surgeons to join the general provident fund. It should, however, be optional to them to join it and no compulsion should be made.

They should be given increased facilities for taking leave. He himself had asked for leave and had been told that he could not be spared.

The travelling allowances were not sufficient. They were given a railway warrant and no allowance for food, etc. They did not get any daily allowance.

(*General Hendley.*) If the assistant surgeons got a degree after passing the M. B. examination, the sub-assistant surgeons did not grumble. But as a matter of fact most of them joined the medical college after passing the First Arts examination and by putting in

24 February 1919.]

Sub-Assistant Surgeon ABDUL GAFOOR.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

five years in the medical college, as against four years by sub-assistant surgeons, got the degree. Sub-Assistant surgeons should be given the same status as that of assistant surgeons. Sub-assistant surgeons were ready to compete with assistant surgeons after getting five years' instruction in the college. The course for sub-assistant surgeons should be increased from one of four years to that of five years and their status should be improved.

The main reason why civil sub-assistant surgeons objected to joining the military was that they could get no private practice. They came on practically the same pay and no adequate compensation was made to them for the loss of their practice. They did not go for field service for the simple reason that they preferred the peaceful civil life. There was no difference between the classes from which military and civil sub-assistant surgeons were recruited. There was some difference in the standard of qualifications required for admission to the medical school from students for the different classes. For the military no particular standard was laid down, while, in the case of civil sub-assistant surgeons, students could not be admitted without passing the matriculation examination. It would be much better if matriculation were prescribed as the standard for both.

(General Hehir.) His experience was confined to East Africa and he could not speak with authority about the sub-assistant surgeons employed in the other theatres of war. Assuming that a number of these men fell sick during the war and were not found to be very healthy, this could be attributed to the want of physical training which they received. It would be better if some system of physical training were introduced in the school and still better if it could be continued for some time after the school course was over.

If the standards both of educational and professional qualifications were raised, he did not anticipate there

would be any friction with the commissioned officers when they join the station hospitals. At present they joined as sub-assistant surgeons and remained as such. But if they joined with better attainments they might be appointed as health officers or appointed to some other better posts. Their pay might also be raised.

The first essential was to give them higher education. The two classes of assistant surgeons and sub-assistant surgeons should then be amalgamated into one. There should be no subordinate service.

Military sub-assistant surgeons had no chance of treating children and families. They went when called for, but there was no regular arrangement. In some regiments they went and saw the children for two or three months or did so when they went round to look after sanitation, but there was no fixed time for this purpose. They were often sent for too late when the patient was on the point of death and they were blamed for it.

There was no trouble as regards the maintenance of discipline by commissioned officers. The very fact that a man had stars on his shoulders inspired respect. The warrant officer in the Indian Army was an anomaly.

Military training should be given for a period of six months, preferably during the five years' course at the medical college, for if it were given after that it would prolong the period of study. In the alternative it might be given in military staff college after completion of the five years' medical course, but in this case the men should commence to draw their pay as soon as they left the medical college.

(General Cree.) He was in sub-medical charge of the Indian station hospital, Allahabad. There would be no difficulty in combining the station hospital for the Indian troops and the station hospital for British troops and having one big hospital under one commanding officer, in which the Royal Army Medical Corps staff would be working for British troops.

25 February 1919.]

The Hon'ble Colonel C. MACTAGGART.

*(The schemes and questions referred to by witnesses are contained in Volume III.)***At Lucknow, Tuesday, the 25th February 1919.**

PRESENT :

THE HON'BLE SIR VERNEY LOVETT, K.C.S.I., I.C.S. (*President*).

MAJOR-GENERAL G. CREE, C.B., C.M.G., A.M.S.

MAJOR-GENERAL P. HEHIR, C.B., C.M.G., C.I.E., I.M.S.

MAJOR-GENERAL H. HENDLEY, K.H.S., I.M.S.

THE HON'BLE MAJOR-GENERAL G. G. GIFFARD, C.S.I., I.M.S.

S. R. HIGNELL, Esq., C.I.E., I.C.S.

LIEUTENANT-COLONEL A. SHAIRP, C.M.G., Indian Army.

MAJOR M. T. CRAMER-ROBERTS, D.S.O., Indian Army.

MAJOR A. A. MCNEIGHT, I.M.S. (*Secretary*).

HON'BLE COLONEL C. MACTAGGART, C.I.E., M.A., M.B., I.M.S., Inspector-General of Civil Hospitals, United Provinces.

*Written statement.**Answers to questions for witnesses.*

Practically all my service has been spent in civil employment and I have therefore considerable diffidence in putting forward views with regard to reorganisation of the military medical services, but in my opinion military and civil medical organisation in India must be, for many years to come, interdependent. In the past the civil work of the Indian Medical Service has been probably more important than its military work and no scheme for a unified medical service can, in my view, be satisfactory unless it makes proper provision for the civil medical needs of the Government of India and local governments. It must also meet the legitimate aspirations of Indians for a fair share of both the civil and military appointments in a unified Government medical service. Times have changed and are changing rapidly in India and facts, however unpleasant they may be from the point of view of European officials, must be faced.

I have no hesitation in saying that I consider it eminently desirable that a unified superior medical service for India, both for military and civil duties, should be established. The existing system of having dual services—the Royal Army Medical Corps and the Indian Medical Service—has undoubtedly led to friction and jealousy between the two services, and has caused great discontent specially among officers of the Indian Medical Service. It is not surprising that this has been the case. The head of the military branch of both services has invariably been an officer of the Royal Army Medical Corps and the administration of the military branch of both services has been in the hands of that Corps. My service has been passed practically entirely in civil employ, so I have no personal knowledge with regard to the treatment of officers of the Indian Medical Service in military employ but practically every officer of the service in military employ, with whom I have come in contact, has complained as to the unfair treatment which he and other officers of the service received as compared with officers of the Royal Army Medical Corps, and this feeling has been undoubtedly largely accentuated during the present war. That it has been operative in adversely affecting recruiting for the Indian Medical Service is certain.

I have carefully considered the schemes 'A', 'B', 'C', and 'D', which have been submitted to me with the list of questions. Scheme 'A' seems to me to be hardly worth consideration. So far as I can judge it appears to be an undisguised attempt to benefit the Royal Army Medical Corps at the expense of the Indian Medical Service. It does not appear to me to make any proper provision for the needs of the civil governments and especially it makes no provision for the maintenance of a sufficient European element in the civil medical service. It is to me utterly inconceivable

that European medical men of good class would ever enter civil employ on the conditions suggested in the scheme as they would, to all intents and purposes, be simply members of a subordinate medical service, and in practice the higher appointments in civil employ would all go to officers of the Royal Army Medical Corps. Further, the scheme absolutely bars military service to Indians and deprives them of the right, which they now have, of entering the commissioned ranks of the military medical service. It is impossible to conceive that under present political conditions in India such a scheme could ever be adopted. Scheme 'B' is a much more practical one and it has much to recommend it, but in my opinion it has two main defects. The first of these is that it maintains the connection of the Royal Army Medical Corps with India, owing to the inclusion in the proposed service of a large number of seconded officers, and will thus to some extent continue the existing friction between the two services, and the second is that it makes no provision for the recruitment of Indian medical men in India and consequently does nothing to meet the legitimate aspirations of Indians for a reasonable share of the higher civil and military medical appointments. Schemes 'C' and 'D' have, in my opinion, the same defects as already pointed out for schemes 'A' and 'B.'

The scheme which I would propose for a unified service is briefly on the following lines:—

The connection of the Royal Army Medical Corps with India should entirely cease and a new service to be called the "Royal Indian Medical Corps" should be organised. It should include all commissioned medical officers serving in India, the members of the Indian Nursing Service, military sub-assistant surgeons, the Army Hospital Corps, the Army Bearer Corps and military hospital establishments generally. Military assistant surgeons should be abolished. I see no reason for retaining the services of military assistant surgeons, whose position has always been an anomalous one, if a proper nursing establishment is maintained in hospitals for European troops and if an establishment of quartermasters and European non-commissioned officers is maintained for disciplinary purposes in European military hospitals. The medical work done in such hospitals by the present military assistant surgeons could easily be carried out by military sub-assistant surgeons. The abolition of the military assistant surgeons would carry with it the great advantage of setting free all the reserve civil appointments now held by officers of that class as additional reserve appointments for commissioned medical officers and for civil assistant surgeons, whose functions in the war reserve I will deal with later on. Military assistant surgeons do not exist in hospitals in other countries and there is no reason for their continued existence in Indian hospitals. All officers of the Indian Medical Service

25 February 1919.]

The Hon'ble Colonel C. MACTAGGART.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

in civil and military employ would of course be transferred to the new Corps. The difficulty of manning the new service and of replacing the officers of the Royal Army Medical Corps now serving in India can be met by action in two directions.

- First* by obtaining a large number of volunteers for the new unified service from the Royal Army Medical Corps, and
- Second* by giving commissions in it to a considerable number of selected men among those now holding temporary commissions in the Indian Medical Service.

To obtain volunteers from the Royal Army Medical Corps it will be necessary to offer considerable inducements in the way of increased emoluments and an increase of pay and allowances on a scale of at least 33½ per cent. will certainly be necessary. I do not think it is necessary for me to go into particulars as to what inducements must be held out to obtain volunteers from the Royal Army Medical Corps and to ensure the recruitment of a sufficient European element in the future unified service, as these are questions which probably do not fall within the scope of the Reorganization Committee's references.

Presuming a unified service, established as I have suggested above, I consider that it should be recruited permanently up to 50 per cent. in England and 50 per cent. in India. Recruitment in England might be effected either by competitive examination or preferably by nomination by the Heads of medical schools arranged for by the Secretary of State. In India recruitment should be by competitive examination and selected candidates should be compelled to go to England for two years, this period to be spent by the candidates in the study of midwifery and gynaecology and in hospital appointments. We have established medical colleges in India where we profess to give a good class medical education. The degrees we confer are registrable qualifications in the United Kingdom and their holders are entitled to compete for entrance to the Indian Medical Service, and it is in my view absurd to suppose that we can long continue to handicap our own students by making them go to England to compete for entrance to the service. It is certain that the principle of simultaneous competitive examination in England and India must be sooner or later recognised as the method of entry into all the higher Indian services and it, or a modification of it, will be the method of entrance into the future medical services whatever the Committee decides. It is best to recognise facts now, concede the principle of proposed recruitment in India and secure in the future a 50 per cent. European element in the service in the way I have suggested above.

As regards the maintenance of a war reserve for the superior ranks of the proposed service that can only be obtained, at any rate so far as the European element for the service is concerned, by the maintenance of the existing system whereby a large proportion of the officers of the service are ordinarily employed in civil appointments under the Government of India and local governments. It would be absolutely impossible to maintain in peace time in employment at military hospitals the number of officers which would be required in an ordinary war emergency and European officers could not be obtained in such an emergency in this country from any source except from Government service. Roughly speaking, the present Indian Medical Service reserve of officers in civil employ gives, I believe, an effective reserve of about 300 officers and until the present war emergency—an emergency which humanly speaking is not likely to recur—this reserve has always been sufficient for army needs in India. By the abolition of the military assistant surgeons at least a hundred of the present civil appointments normally held by them could be made available as reserve appointments for commissioned medical officers and the reserve of such could be correspondingly increased. This reserve must be maintained and the Government of India must make it perfectly clear that the necessary number of appoint-

ments in civil employ will, under all circumstances, be maintained for the reserve officers in the new service. A further emergency reserve, which would ensure the services of a large number of officers in any great emergency, can be obtained by making all civil assistant surgeons in the employ of local governments liable for military duty as commissioned officers of the new service during the first ten or fifteen years of their service; and this liability should be made effective either by a bond carrying a deterrent monetary penalty or by bringing these men under the provisions of the Army Act for a definite period. I believe there would be no difficulty whatever in local governments enlisting civil assistant surgeons willing to undertake this liability, if a reasonable rate of pay is offered, and in any case a revision of the scale of pay of civil assistant surgeons must, on general grounds, soon be undertaken. The initial pay of these officers is Rs. 130, it should be raised to Rs. 200 or Rs. 250 and liability to military service in an emergency made obligatory as I have suggested above.

As regards the war reserve of sub-assistant surgeons it can only be obtained by making all sub-assistant surgeons employed by the Government of India and local governments on civil duty liable for military duty for a definite period, say the first ten or fifteen years of their service, in the same way as I have suggested in the case of civil assistant surgeons. Military sub-assistant surgeons should have Indian commissions as jamadars and subedars according to length of service. I may here point out that if under any extension of local self-government, civil assistant surgeons and sub-assistant surgeons cease to be Government servants and become the employés of district boards or divisional councils the possibility of using them as a military reserve will practically disappear. This is one—but only one—of the many objections to the destruction of the provincial medical services which will be involved by an extension of local self-government on the lines recently suggested by a resolution of the Government of India on the subject.

I cannot see that the relations of officers of a unified service towards private practitioners need differ in any way from those now existing between officers of the Royal Army Medical Corps, the Indian Medical Service and private practitioners. If the unified service is to obtain European recruits of decent class the right of officers of the service to engage in private practice, so long as it does not interfere with their public duties, must be maintained. I see no possible way of utilising private practitioners as a war reserve unless conscription of doctors is to be resorted to and that expedient is, I presume, entirely out of the question. Private practitioners, whose services would be worth having, are not likely to leave their practice during war if they can possibly help it. Besides, even in war the medical needs of the civil Government and of the public must receive consideration and if commissioned officers in civil employ and civil assistant surgeons form a war reserve their civil duties (when they are mobilised) can only be taken over by private practitioners. In short no attempt should in my opinion be made to form a war reserve from private practitioners, these practitioners should be the civil reserve, the men available for temporary recruitment by local governments to take the place in civil employment of commissioned medical officers and civil assistant surgeons going on military duty.

I consider that officers of the new service should serve for five years on military duty before being eligible for civil appointments and when an officer has entered civil employ he should remain in such employ until he reaches, say 18 years' service. To move officers from military to civil and civil to military employ at intervals during their service would merely result in inefficiency. At 18 years' service an officer in civil employ should be asked definitely to decide whether he wishes to remain in civil employment or not. If he wishes to do so he should be allowed to remain in civil employ and his liability to reversion to military duty should cease at a definite period of his service, say 23 years. Promotions to administrative

[24 February 1919.]

The Hon'ble Colonel C. MACTAGGART.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

military appointments should be reserved entirely for officers in military employ and similarly promotions to administrative civil appointments for officers in civil employ. I see no reason whatever why officers in civil employ promoted to administrative civil appointments should not receive the rank of colonel. No one can, I think, assert that the duties of an officer in charge of the civil medical administration in a great province like Bengal, Madras, Bombay, the United Provinces and the Punjab are less onerous and do not require at least as much administrative ability as those devolving on an officer holding the position of Assistant Director of Medical Services of a military division. I see no reason why any particular change should be made in the methods of mobilisation of officers in civil employ. The percentage of officers to be given up on mobilization by each local government should be fixed as at present and it should be left to the local government to say what officers it will surrender for military duty and what officers it will retain. The relative position and duties of the Director General and Director, Medical Services, who would of course be officers of the same Corps, might, so far as I can see, remain much as they are now and I cannot see that any advantage would be obtained by the appointment of an advisory board to regulate promotions as suggested in scheme 'B.' In order to maintain uniformity between military medical administration in India and England, officers of the Indian service in military employ prior to promotion to the rank of lieutenant-colonel and again prior to promotion to administrative rank should be attached for one year to the Royal Army Medical Corps in England. An Indian Army Medical College should be established in India and it might be connected with the new Calcutta School of Tropical Medicine.

I do not see that it is necessary for me to say anything here with regard to what I consider the conditions of pay, pension and service in the new service should be. It is sufficient to say that in order to attract the number of European recruits necessary the conditions of service must be very much more attractive than those of the Royal Army Medical Corps and they must be sufficient to attract the best class of candidates from British medical schools.

I believe that the scheme which I have outlined above would meet the needs of the army in India and the civil requirements of India. Whether it would meet with the approval of the War Office is another matter. Probably no scheme not prepared by that office would meet with its approval. Given sufficient inducements in the shape of pay and favourable conditions of service, I do not see why professional opinion in England and India should not be satisfied with such a scheme. It would meet the needs of the civil administration in India as well as the existing system does and I have no reason to believe that the existing system does not meet those needs satisfactorily. I have already stated that I think the scheme I propose would give a sufficient and effective reserve for military purposes, especially if supplemented, as I have suggested, by a large reserve of civil assistant surgeons, and the reserve officers would all have a training in military work and would all be available in India.

It is impossible for me to give an opinion with regard to whether the existing Indian Medical Service reserve of officers in civil employ has proved of value in the war or not but as more officers were surrendered from civil duty than it was ever expected could be so surrendered, I take it that, as regards numbers at least, the reserve was effective and of value.

I have no suggestions to make as regards the rules for the grant of study leave or as regards the provision of a special department of research. I have heard no complaints from officers with regard to the existing rules for study leave.

With regard to the effect of the withdrawal of officers of the Indian Medical Service from the charge of civil districts and jails owing to the war, I may say that it has undoubtedly, as was only to be expected, resulted in a temporary decrease in efficiency. The ordinary

work in civil hospitals has been carried on, on the whole, very fairly well by the temporary officers who have been placed in charge of them and there have been no indications of any diminution in the work done in these institutions. Where temporary officers have failed has been in medico-legal work, with regard to which there have been numerous complaints from courts and police, and in the administrative work of jails and other institutions. There has undoubtedly been a serious falling off in the discipline and in the efficiency of the general management of the jails. With the return of permanent civil officers from military duty I have not the least doubt that the former standard of efficiency will be rapidly regained, and, so far as I can see, the lesson of the war is that it is possible for local governments to surrender a large proportion of their medical officers in a military emergency and still manage to maintain for a considerable time fairly efficient medical, sanitary and jail administration provided that the administrative officers and a proportion of the senior commissioned medical officers are left in civil employ.

With regard to the question as to how far private practice has declined in the case of Indian Medical Service officers in civil employ, I have no hesitation in saying that there has been, except in a few stations, a marked decline in private practice. Outside of a few big stations, in the United Provinces the private practice now amounts to practically nothing. The chief reason for the decline is the large increase in the number of very competent and able Indian private medical practitioners who are now practising throughout the Provinces, the great improvement in the means of communication has further tended to throw private practice into the hands of men in the larger towns and correspondingly diminish the practice of civil surgeons in small stations. Take for example the case of Oudh. The private practice in stations like Sitapur, Bahraich and Gonda was formerly considerable; now well-to-do people in these places requiring medical or surgical advice go straight into Lucknow, where most of them have private houses, and are treated there chiefly by well-known Indian private practitioners.

Answers to special questions.

It is quite impossible to say how far the demands of European members of the public services for European medical attendants are based on purely racial predilection and how far on the comparative professional merits of doctors educated in the United Kingdom and India. Both these factors are operative, but in my opinion they are both diminishing in intensity. European men now rarely object to be treated by competent Indian practitioners but European women do object in most cases and European men object to their wives being treated by Indians. Since the war began and the services of European practitioners were in many civil stations not available it has been necessary for European women to accept treatment by Indian and on the whole the complaints which have reached me with regard to this matter have been very few. It is undoubtedly the case that doctors educated in the United Kingdom are better educated professionally and inspire more confidence as a class than those educated in India, especially as regards diseases of women and children. With the progress of medical education in India and the diminution in race prejudice, which is undoubtedly gradually taking place, I am confident that Europeans will gradually be less unwilling to accept medical aid from Indians than they now are.

As I have already said complaints from Europeans with regard to the treatment received from Indian substitutes for the European medical officers withdrawn from civil to military duty, on account of the war, have been very few indeed. No doubt this has largely been due to the fact that European officials have loyally accepted the situation caused by the war and have recognised that the best which it was possible to do was being done for them, but it also indicates

25 February 1919.]

The Hon'ble Colonel C. MACTAGGART.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

that the Indian practitioners concerned were as a class neither inefficient nor tactless. By maintaining active and efficient European civil surgeons in the provincial hill stations English women during the hot weather have in most cases had the services of European medical officers at their disposal during a large part of the year. During the cold weather the few Indian Medical Service officers left in civil employ in large stations have been resorted to as consultants and they have gone to outlying stations where their services are required for confinements. European women have gone to the hills or to hospitals or nursing homes in the larger stations.

I have seen little of Indian Medical Service officers of less than five years' service for some years past. As regards officers who have served under me I have certainly noticed no deterioration and inefficiency in their work.

Answers to special questions to be asked from service officers.

I served in military employ for a little over three years at the beginning of my service and the remainder of my total service of 33 years has been spent in civil employ.

I have personally no cause of complaint. It has been my good fortune to serve for 20 years at the headquarters of the United Provinces Government as Inspector-General of Prisons and Inspector-General of Civil Hospitals and I have received nothing but the utmost consideration and kindness from the local government which I have had the honour to serve. I have felt that my pay in both the appointments mentioned was, considering the work and responsibility which devolved on me, less than it should have been especially in comparison with the pay given to heads of other departments, but, as I have had no children to educate, I have managed to get along and I have never officially complained. I quite recognise that I have been probably more fortunate than most other officers of the Indian Medical Service, who in general have had much less reason to be satisfied with their service conditions.

In the appointments which I have held I have naturally not been brought into contact, except socially, with officers of the Royal Army Medical Corps, so no opportunities for friction between me and officers of the Corps have occurred.

I know, as I have already stated in my answer to the "general questions," that officers of my service feel intensely aggrieved with the treatment they receive as compared with officers of the Royal Army Medical Corps. The only way to end the friction is, as I have already suggested in my reply to the "general questions," to entirely sever the connection of the Royal Army Medical Corps with India.

As I have mentioned in my reply to the "general questions," I consider that transfers from military to civil employment should take place after about five years' service, that permanent transfers from civil to military employ should not be allowed later than 18 years' service and that liability to recall for military duty from civil employ should cease at 23 years' service.

Answers to questions regarding Medical Stores Department.

At present in these provinces, Government hospitals, jails, asylums, etc., get their supplies from medical store depots, but district board hospitals and dispensaries make their own arrangements for their medical supplies and buy them in the open market subject to the limitation that they must deal with firms recognised by Government as of good standing. So far as I know the existing practice works well and I see no reason to change it. To compel local bodies to get their supplies from medical store depots might certainly result in the depots being able to turn over their stock of drugs quicker and allow of their keeping larger reserve stocks, but on the other hand it would in all probability seriously interfere with the operations of many large

firms which now trade in drugs in India and would probably thus result in no increase in the total available stock of drugs in the country at any given time. I do not believe that to compel all local medical institutions to get drugs and appliances from medical store depots would result in economy. It seems to me that healthy competition between respectable firms is likely to keep down the price of drugs in India. The way in which the Government quinine factories have raised their price for quinine during the war and the way in which they have arbitrarily cut down civil indents does not encourage one to extend dealings with medical store depots. The matter is not one on which, on the facts before me, I can form any definite views. Unless good reasons can be produced for a change I would let matters stand as they are. Indents on the medical store depots for Government institutions are prepared by the medical officers in charge and are checked and countersigned by the Inspector-General of Civil Hospitals. Indents for supplies for district board and other local institutions are made direct on the supplying firms by the medical officers concerned.

Answers to questions to be asked of officers, regarding assistant surgeons and sub-assistant surgeons.

I have incidentally dealt with most of these questions in my answers to "general questions."

I attach a copy of the form of bond for civil sub-assistant surgeons which is prescribed in these provinces. It makes such sub-assistant surgeons liable for civil or military duty anywhere in India for the period of five years of their service under a penalty of Rs. 400. No alteration has been made in it during the war. The conditions in the bond have been enforced in practically all instances in which a civil sub-assistant surgeon has refused to proceed on military duty in India. About 25 such cases occurred during the war.

I would alter the conditions of the bond in view of the experience gained during the war so as to make service anywhere on civil or military duty in or out of India compulsory for the first ten years of service under a penalty of Rs. 1,000. If this were done there would be no occasion for making the bond renewable.

As far as I can see the conditions of service of civil sub-assistant surgeons are generally satisfactory, except as regards their pay which in these provinces will be shortly increased to a reasonable figure.

The provinces supplied from its civil cadre during the present war for military duty 23 permanent assistant surgeons, 11 health officers of the assistant surgeon class, 30 temporary assistant surgeons and 159 sub-assistant surgeons. Of course the absence of these men caused some dislocation of medical and sanitary work but the difficulty was tidied over as much as possible by the employment of temporary men, most of whom, in the case of substitutes for sub-assistant surgeons, were compounders and unqualified men. It was impossible to spare more medical subordinates for military duty but the cadre of civil medical subordinates is constantly increasing, for example, in the year 1903 the cadre of civil sub-assistant surgeons in the provinces was 388 and it is now 556 and in future wars no doubt the number who can be spared for military duty will consequently correspondingly be greater than it is now.

I have already said in reply to the general question that civil assistant surgeons should form an emergency war reserve for commissioned medical officers. As a condition of their appointment they should be liable for civil and military duty anywhere in or out of India for first ten years of their service and their emoluments and conditions of service should be improved so as to compensate for this liability.

The existing civil medical arrangements meet the requirements of Government and the general public so far as they go but the demand for medical aid is constantly increasing and the demand is constantly being met so far as the means of Government permit of this being done. There is no reason to believe that this extension of medical aid will not be gradual and

25 February 1919.]

The Hon'ble Colonel C. MACTAGGART.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

continuous. I believe the present system of control and supervision, that is to say central control by an administrative medical officer of experience, subject to the general orders of Government, to be the best and most efficient possible. I am strongly opposed to making over the control of medical establishment and medical institutions to district board or divisional council or to lay control in any shape or form.

I have nothing to say with regard to military sub-assistant surgeons' capabilities. The education in the Agra Medical School, which is now the largest medical school in India and which is under my administrative control, is I think, very fairly good and is constantly being improved. The local government proposes to increase the educational course for sub-assistant surgeons at Agra from 4 to 5 years and to make numerous other improvements in the educational machinery of the school as soon as possible after the war and the military sub-assistant surgeons trained there will benefit by these improvements equally with the civil sub-assistant surgeons.

I cannot understand the purport of question No. 10.

Civil assistant surgeons and sub-assistant surgeons are required for civil work and they could not possibly be spared for ordinary military duty in Indian station hospitals. Obviously they can only be lent to the military department in a war emergency.

As I have already stated I think the military assistant surgeon should be abolished. With a proper nursing establishment and properly trained military

sub-assistant surgeons in military hospitals, I fail to see where the necessity for his retention comes in and his abolition would provide the means for a large increase in the reserve of commissioned officers in civil employ. From the civil point of view there is no necessity for his continued existence and the only help the civil Government got during the war from the military assistant surgeon class was that a few retired military assistant surgeons were available for civil employment. The military assistant surgeon's position at present is an absurd one. He is a doctor and yet he is not a doctor, as his qualification is not registrable in the United Kingdom. If he is given a registrable qualification his usefulness as a military medical subordinate will be destroyed and he would immediately claim, and with some reason, professional equality with commissioned officers under whom he might be serving. On the other hand when he is sent to civil duty and appointed as a civil surgeon he is placed in command over civil assistant surgeons who have registrable qualification and as a class are professionally his superiors. Military assistant surgeons should in my opinion no longer be recruited. Indian-bred Europeans and Anglo-Indians trained in Indian medical colleges if given a registrable qualification would, if the proposals I have made for partial recruitment in India for a new unified medical service be adopted, be under no disadvantage. They could compete in India on fair terms with Indians in a competitive examination for admission to the proposed new service.

The following memorandum was prepared for the Medical Services Reorganization Committee by the Inspector-General of Civil Hospitals, United Provinces, after discussion with the Lieutenant-Governor. It is in accord with the views of the Government except that the Lieutenant-Governor prefers to reserve judgment on the question of the bearing of the proposals on a possible extension of local self-government which is referred to at the end of paragraph 4 of the memorandum.

- (1) *The desirability or otherwise of the creation of a unified superior medical service for India, both for military and civil duties.*

I have no hesitation in saying that I consider it eminently desirable that a unified superior medical service for India, both for military and civil duties, should be established. The existing system of having dual services—the Royal Army Medical Corps and the Indian Medical Service—has undoubtedly led to friction and jealousy between the two services, and has caused great discontent especially among officers of the Indian Medical Service. It is not surprising that this has been the case. The head of the military branch of both services has invariably been an officer of the Royal Army Medical Corps and the administration of the military branch of both services has been in the hands of that Corps. My service has been spent practically entirely in civil employ, so I have no personal knowledge with regard to the treatment of officers of the Indian Medical Service in military employ, but practically every officer of the service in military employ with whom I have come in contact has complained as to the unfair treatment which he and other officers of the service receive as compared with officers of the Royal Army Medical Corps and this feeling has been undoubtedly largely accentuated during the present war. That it has been operative in adversely affecting recruiting for the Indian Medical Service is certain. I can see no reason why the work now done by the Royal Army Medical Corps in India should not be done quite as effectively by the officers of an enlarged Indian Medical Service, and I cannot see that there is any argument which can be reasonably brought forward in favour of the necessity for the maintenance of the connection of the Royal Army Medical Corps with India.

- (2) *If it is decided to proceed with the formation of a unified medical service what would be the best method of carrying out the proposal.*

The new service should be called the Royal Medical Corps. It should include all commissioned medical officers serving in India and also the military assistant surgeons, military sub-assistant surgeons and the Army

Bearer Corps. The main difficulty in carrying out the proposal would seem to be as regards recruitment, and the necessity for obtaining sufficient medical officers to replace the officers of the Royal Army Medical Corps now serving in India. This, so far as I can see, can only be effected in two directions.

First by obtaining a large number of volunteers for the new unified service from the Royal Army Medical Corps, and

Second by giving commissions in it to a considerable number of selected men among those now holding temporary commissions in the Indian Medical Service.

To obtain volunteers from the Royal Army Medical Corps it will be necessary to offer considerable inducements in the way of increased emoluments and an increase of pay and allowances on a scale of at least 33½ per. cent. will certainly be necessary. I do not think it is necessary for me to go into particulars as to what inducements must be held out to obtain volunteers from the Royal Army Medical Corps and to ensure the recruitment of a sufficient European element in the future unified service, as these are questions which probably do not fall within the scope of the Reorganization Committee's references.

Presuming a unified service, established as I have suggested above, I consider that it should be recruited permanently up to 50 per cent. in England and 50 per cent. in India. Recruitment in England might be effected either by competitive examination or by nomination by the heads of medical schools arranged for by the Secretary of State. In India recruitment should be by competitive examination and selected candidates should be compelled to go to England for two years, this period to be spent by the candidates in the study of midwifery and gynaecology and in hospital appointments.

- (3) *The relation to or the inclusion of the subordinate medical service in a unified medical service.*

As I have already indicated military assistant surgeons, military sub-assistant surgeons and the Army

25 February 1919.]

The Hon'ble Colonel C. MACTAGGART.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

Bearer Corps should be included in the unified service. Military assistant surgeons should have warrant or honorary commissioned rank according to seniority and military sub-assistant surgeons should have Indian commissioned rank. It would I believe greatly simplify matters if the military assistant surgeons could be abolished and his place taken in military hospitals by military sub-assistant surgeons and quartermasters. By the abolition of military assistant surgeons many more reserve civil appointments would be available for commissioned medical officers and for provincial civil assistant surgeons, who if my suggestions are carried out, would be available for military duty in emergencies.

- (4) *The maintenance in civil employment of an adequate war reserve in the ranks of both the superior and subordinate medical service.*

As regards the maintenance of a war reserve for the superior ranks of the proposed service there is no possible way, so far as I can see, in which such a reserve can be maintained at any rate for the European element in the service—except by the maintenance of the existing system whereby a large proportion of the officers of the service are ordinarily employed in civil appointments under the Government of India and local governments. It would be absolutely impossible to maintain in peace time in employment in military hospitals the number of officers which would be required in an ordinary war emergency, and European officers could not be obtained in such an emergency in this country from any source except from Government service. Roughly speaking the present Indian Medical Service war reserve of officers in civil employ gives I believe an effective reserve of about 300 officers, and until the present war emergency—an emergency which humanly speaking is not likely to recur—this reserve has always been sufficient for the needs of the army in India. This reserve must be maintained and the Government of India must make it perfectly clear that the necessary number of appointments in civil employ will under all circumstances be maintained for the reserve officers in the new service. A further emergency reserve, which would ensure the service of a large number of officers in any great emergency, can be obtained by making all civil assistant surgeons in the employ of local governments liable for military duty as commissioned officers of the new service during the first ten or fifteen years of their service; and this liability should be made effective either by a bond carrying a deterrent monetary penalty by bringing these men under the provisions of the Army Act for a definite period. I believe there would be no difficulty whatever in local governments enlisting civil assistant surgeons willing to undertake this liability, if a reasonable rate of pay is offered, and in any case a revision of the scale of pay of civil assistant surgeons must, on general grounds, soon be undertaken. The initial pay of these officers is Rs. 130, it should be raised to Rs. 200 or Rs. 250 and liability to military service in an emergency made obligatory as I have suggested above. I would have a distinct rule that officers of the unified service in civil employ should not be eligible for administrative military appointments, and similarly the administrative civil appointments should be reserved for officers of the service in civil employ. The reasons for this suggestion are, I think, clear. As regards the maintenance of a war reserve of military assistant surgeons this can only be obtained as it is at present, that is to say definite number of civil appointments under the Government of India and Local Governments must be reserved for officers of this class. I do not see how it is possible to employ a substantially larger number of commissioned officers than those included in the present cadre in civil employ. It certainly could not be done in these provinces without abolishing the reserve appointments of military assistant surgeons. So far as I can see the reserve of 300 commissioned officers in civil employ plus the reserve I have suggested of civil assistant surgeons should be enough to meet any emergency which is ever likely to happen.

As regards a war reserve of sub-assistant surgeons it can only be obtained by making all sub-assistant

surgeons employed by the Government of India and local governments on civil duty liable for military duty for a definite period, say the first ten or fifteen years of their service, in the same way as I have suggested in the case of civil assistant surgeons.

I may here point out that if under any extension of local self-government civil assistant surgeons and sub-assistant surgeons cease to be Government servants and become the employes of district boards or divisional councils the possibility of using them as a military reserve will practically disappear. I have already drawn attention to this danger in my demi-official letter No. 373-C., dated the 24th September 1918, to the address of the Hon'ble Mr. Sim, and I need not elaborate the point further. It is one—but only one—of the many objections to the destruction of the provincial medical services which will be involved by an extension of local self-government on the lines suggested by the Committee of the Legislative Council which recently sat to consider the matter of extending local self-government.

- (5) *The relations between independent medical practitioners in India (both European and Indian) and the unified medical service, with special reference to the formation of a war reserve of all ranks.*

I do not quite follow what the above quoted reference means. I cannot see that the relations of officers of a unified service towards private practitioners need differ in any way from those now existing between officers of the Royal Army Medical Corps and Indian Medical Service and private practitioners. If the unified service is to obtain European recruits of decent class the right of officers of the service to engage in private practice, so long as it does not interfere with their public duties, must be maintained. I see no possible way of utilizing private practitioners as a war reserve unless conscription of doctors is to be resorted to and that expedient is, I presume, entirely out of the question. Private practitioners, whose services would be worth having, are not likely to leave their practice during war if they can possibly help it. Besides even in war the medical needs of the civil government and of the public must receive consideration and if commissioned officers in civil employ and civil assistant surgeons form a war reserve their civil duties (when they are mobilized) can only be taken over by private practitioners. In short no attempt should in my opinion be made to form a war reserve from private practitioners, these practitioners should be the civil reserve, the men available for temporary recruitment by local governments to take the place in civil employment of civil surgeons and civil assistant surgeons going on military duty.

- (6) *The future organization of the Medical Store Department and the relations of the Local Governments to it. Whether, amongst other questions, the Local Governments would purchase all their medical and surgical requirements from the depots of the Government Medical Stores Department.*

At present Government hospitals, jails, asylums, etc., get their supplies from medical store depots, but district board hospitals and dispensaries make their own arrangements for the medical supplies and buy them in the open market subject to the limitation that they must deal with firms recognised by Government as of good standing. So far as I know the existing practice works well and I see no reason to change it. To compel local bodies to get their supplies from medical store depots might certainly result in the depots being able to turn over their stock of drugs quicker and allow of their keeping larger reserve stocks, but on the other hand it would in all probability seriously interfere with the operation of many large firms which now trade in drugs in India and would probably thus result in no increase in the total available stock of drugs in the country at any given time. The matter is not one on which, on the facts before me, I can form any definite views. Unless good reasons can be produced for a change I would let matters stand as they are.

25 February 1919.]

The Hon'ble Colonel C. MACTAGGART.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

Answers to questions by the Government of the United Provinces.

1. (a) From the point of view of the civil medical administration the Government would not be in favour of compulsory military training for any portion of the civil assistant and civil sub-assistant surgeon cadres in peace time. It would disorganize the service and render it unpopular. Government doubts whether the advantage would counterbalance the disadvantages of such disorganization. The Government would have no objection to their spending the first year or two of their service in military service.

(b) The Local Government considers that if necessary, it should have the right to appoint an outsider (a non-service man) of special qualifications to any particular appointment.

2. This question is not sufficiently definite to allow of an answer being given.

3. (a) The Government would not be in favour of making it an unalterable condition of appointment that non-service men should belong to the reserve, but it would wish to retain the option of making it a condition of appointment if the person appointed seemed to it to be suitable for the reserve. This would apply both to Europeans and Indians.

(b) The Government has no experience on which to base a reply.

4. The Government is not in favour of forming a reserve from the private medical practitioner class as they would be wanted to take the place of civil assistant surgeons called to military duty. The best way the Government considers of forming an emergency reserve is to make civil assistant surgeons liable for military duty during the first fifteen years of their service.

5. Occasions have arisen more than once when the

Government found that the present leave reserve was insufficient. The Government should have a freer hand in allowing officers to go on leave in excess of the limit now laid down provided it can make local arrangements.

6. The Government would strongly favour free treatment of the wives and children of all civil officers, but this should be taken into consideration in fixing the pay or allowances of the medical service.

7. The suggestion might involve the treatment of such very large numbers if it would apply to Government servants of all classes that the Government is not prepared to give a definite opinion.

8. So far as the Government is aware, there is no demand or necessity for travelling consultants or travelling medico-legal experts.

9. From the point of view of the civil medical administration the Government is opposed to sending officers in civil employ back to military employ at intervals. It would cause too great a dislocation of civil work. It is proposed that the officers should spend their first five years in military service, and that at 18 years they should either revert to military duty or stay permanently in civil employ.

10. Indians must get a larger share in the appointments in the medical service in future, but at the same time it must be remembered that in all other services Indians will be obtaining a larger share and consequently the demand for European medical officers by European families will be less than it was in the past. Racial predilections are on the decrease and though there may be occasions of friction, the Government does not anticipate that they will be either frequent or serious.

11. The Inspector-General of Civil Hospitals has dealt with this point in his evidence.

Statement showing the authorized cadres of the various categories of medical personnel in the United Provinces, the numbers on the rolls at the outbreak of the recent war and the number given up for military duty.

Class of officers.	SANCTIONED CADRE.			Number on rolls before the war.	Number to be relinquished on mobilization.	Actual number reverted to military duty on account of war.	REMARKS.
	Appointments.	Reserve.	TOTAL.				
Indian Medical Service officers .	46 (a)	9	55	57 (b)	38 (b)	42 (b)	(a) Administrative appointments . 3 1st class Civil Surgeoncies . 4 2nd class Civil Surgeoncies . 20 Jail Superintendents . 6 Lunatic Asylum . 1 Deputy Sanitary Commissioners 2 College appointments . 4 46
Indian Medical Department officers— (Military Assistant Surgeons) .	21 (c)	2	23	24	Whole	23	(b) Excluding 7 Plague officers. (c) Civil Surgeoncies . . . 11 Subordinate charges . . . 10 21
Provincial Medical Service .	8	..	8	8	Nil	Nil	
Civil Assistant Surgeons . .	93 (d)	15	108	108	Nil	23	(d) All subordinate charges.

THE HON'BLE COLONEL C. MACTAGGART, Inspector-General of Civil Hospitals, United Provinces and also as the Representative of the United Provinces Government, called and examined.

(President.) He would recruit for the unified service on the basis of military needs, and the reserve of that service would fill civil needs. The present Indian Medical Service filled civil needs, and the new service would do likewise. You could not employ more officers of the new service in civil employ than was now done, except by abolishing the military assistant surgeon and making over a certain number of civil surgeoncies to the new service. You would in that way increase the new service and also the military reserve.

The vacancies which had been caused in the civil medical cadre of the United Provinces had been filled in various ways, namely, by the employment of retired officers, but did not get many in that way. They had obtained altogether 2 Indian Medical Service officers

and 5 or 6 military assistant surgeons, retired. They had also employed a certain number of private practitioners, a small number, about 7. The private practitioners were not as good on the whole as the assistant surgeons, whose inferiors were employed as civil surgeons, with one or two exceptions. Most of the appointments had been filled by giving temporary promotion to assistant surgeons. They filled the place of the assistant surgeons by the employment of temporary officers, generally men from the Lucknow Medical College, or wherever they could get them from. They were employed as assistant surgeons and took the place of the assistant surgeons, who were promoted to civil surgeons, and also the place of those assistant surgeons who had gone on military duty.

25 February 1919.]

The Hon'ble Colonel C. MACTAGGART.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

The number of independent medical practitioners of the better class was increasing rapidly, and they were undoubtedly also increasing very much in efficiency. There were some excellent men among them.

The military war reserve would only fill, as now, a proportion of the total number of civil appointments, and it would therefore be unnecessary to employ more officers of the Imperial Service in civil than at present. They would be supplemented by provincial recruitment. There was at present no difficulty in increasing the number of doctors recruited provincially.

They could get 5 men for every vacancy that occurred, although they were badly paid at present. There was very little opening in the provinces for Indian doctors of the better class, while there was room for hundreds of the sub-assistant surgeon class. The better class doctor was overstocked in the United Provinces, and there was not sufficient employment for the men graduating from the medical college. A certain number would enter the Sanitary Service, when it was enlarged, although as a rule this service was not popular.

(President.) The want of employment for medical practitioner was, he considered, due to a mixture of ignorance and poverty on the part of the Indian public, who preferred vaidas and hakims for their cheap medical attendance, though at the end they called for the doctor, as a rule. The business of hakims and vaidas was not holding its ground so much at present: but their elimination was a very slow and gradual process.

Every civil assistant surgeon should be liable for military duty for a certain period, say the first 15 years of his service; and in case of war, the service officer would also go. It was absolutely impossible for Government to carry on without obtaining the services of private practitioners, who should form the civil reserve to take the place of the men going on military duty. You would not get private practitioners of any standing to join a military reserve. They would not give up their livelihood, as by the time they returned from military duty their practice would be gone.

Although the service that he contemplated would be a very large one, he did not see why it should not be efficiently managed under one head. He could not tell what the strength of the new service would be; but roughly it would be the present combined strength of the Indian Medical Service and the Royal Army Medical Corps in India. He was calculating on a 50 per cent. recruitment in India, which was the basis of his scheme. He did not absolutely lay down 50 per cent. as essential. His main object in proposing 50 per cent. was to ensure that the European element should be a large one, which could not be obtained in any other way.

He would not have simultaneous examinations and would not have any examinations at all in England. He advocated nomination in the case of candidates at Home. Even if they had examinations at Home, it did not follow that these should be identical with those in India. They may be of the same standard but not necessarily identical. He would not favour examinations at Home, as very likely candidates from India would go Home to compete. That was his reason for suggesting nominations in the place of examinations.

(General Cree.) In view of present political conditions, it would be difficult to lay down that all Indians ought to compete in this country, so that nomination would be the best method.

(President.) They had all castes undertaking medical work; he had some good Mahomedans and buniahs. Many men of the same class as the ordinary deputy collector entered the medical service. The candidates were about the average of those who joined the public services.

The witness then read out the replies of the Government of the United Provinces to the special questions

for local governments, and in answer to queries arising from them made the following statements:—

With regard to question 1, from the point of view of the civil medical administration, the United Provinces Government would not be in favour of compulsory military training for any portion of the civil assistant surgeons and sub-assistant surgeons cadre in peace time. His Honour thought that if a man was to be sent to military service once in every five years, it would obviously mean at once an increase of one-fifth in the cadre. That would be a great inconvenience, as they would have to change so many appointments every year. This would be almost impossible in practice and would make the service very unpopular. It would render the security of the tenures of appointments very doubtful; therefore the United Provinces Government could not consent to it. There was no objection to sending every man for 2 years or one year to military duty when first appointed and before actually taking up civil duties.

With regard to question 2, the feeling of the United Provinces Government was that, as regards professional appointments, they should choose the best man they could get, whether belonging to the service or a private practitioner, and from India, England or anywhere. They would not object to the Government of India making these appointments, but they would expect to be consulted.

With regard to question 3, they may want to appoint an old man for some job, and would not like to force him to join a reserve. Under ordinary circumstances they would, if the candidate was a suitable person to go into the reserve.

With regard to question 5, the United Provinces Government considered that they should be allowed to send as many of their officers on leave as they liked, so long as they did not ask the Government of India to replace them. The Civil Service Regulations were not sufficient, as far more men wanted to go on leave than the regulations permitted to do so.

With regard to question 6, it was the greatest possible mistake, from the point of view of the Indian Medical Service, that civil officers should have to pay for the medical treatment of their wives and families. This led to a great deal of friction between the Indian Medical Service and the civil services. Civil officers did not think they should pay for medical attendance when military officers did not.

With regard to question 7, they had at present 3 Government hospitals in the United Provinces, and other district hospitals, but Government could not force the district boards to give free treatment to the families of civil officers.

(President.) With regard to the suggestion to guarantee to the wives and families of European officers European medical attendance, he would express no opinion about the military. In civil stations, for many years past, there have always been Indian civil surgeons in small stations. If they had 50 per cent. of European civil surgeons it should be quite easy to arrange matters. As things go on, there will be many stations where there will be no European residents. At present also, communication between adjoining stations was very easy. When a European woman got ill, even if there was an Indian civil surgeon in the station, it was the simplest matter to get a European doctor from the next large station. All she had to do was to ask for a consultation, and the matter could be arranged by the local magistrate.

With regard to hospital treatment, there was plenty of accommodation for Europeans in the various hospitals in the province, which were comfortable and suitable for anyone, and which have been freely used by European women during the war. He did not believe the men cared at all. Ladies also cared much less than they used to do. A number of them expressed entire satisfaction with the treatment they received at the hands of Indian doctors.

The attraction for the Indian Medical Service in a large number of cases, could be explained by heredity. Some men were attracted by an Indian career and the off-chance of making money; but the service was largely

25 February 1919.]

The Hon'ble Colonel C. MACTAGGART.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

manned by people who had known about the Indian Medical Service all their lives and had been brought up and educated to go into it. He did not think it was the attraction of a military career. Very few of the present Indian Medical Service officers, who had sons, would care to put them into the Indian Medical Service or any public service in India.

(General Giffard.) If an officer had done 5 years' military service, he would not necessarily become professionally inefficient. He would not advocate permanent transfers from civil to military employ later than 18 years' service. An officer's military efficiency was not lost by remaining in civil employ. He would not have military regulations at his fingers' ends, but given a reasonable amount of service, there was nothing he could not pick up in a very short time. Officers who had long been in charge of large civil hospitals were doing far more administrative work than men in charge of ordinary Indian station hospitals. They were fit at any time to take up military duties after a little brushing up. It would dislocate civil work very much if an officer had to spend any considerable time in military service.

(General Giffard.) If it was made clear that all civil sub-assistant surgeons must be prepared to do military duty in case of emergency, it would not affect recruiting, provided they were given sufficient pay. They were discontented with their present pay and position. In every case when a sub-assistant surgeon refused to go on military duty he had enforced the bond without any difficulty. He took the full penalty and dismissed the man.

(Mr. Hignell.) If you abolished the military assistant surgeon, as had been suggested by him, there would be a certain number of Anglo-Indians of a fairly good type who could be recruited for the new service. You would not get many Europeans. He would let Anglo-Indians go into the medical college and take their medical degree and compete for this service with Indians. He would make them stand on their own feet. He had suggested 50 per cent. as it was the only way to obtain European recruits. Before the war, and under present conditions, where Indians were handicapped by having to go to England, the Indian Medical Service was getting its 50 per cent., and with better attractions at Home and better chances, they would find that they would get 75 per cent. of Indians. They would swarm Home to England and get into the new service. He had guarded against the latter contingency in the new service by nomination at Home. He contemplated that nomination at Home would result in an entire recruitment of Europeans. He did not think that Indian public opinion would immediately raise an outcry, if they obtained recruitment in India. There was the difficulty that they would want to go Home, but you would not get many going Home. They would prefer to take their chance out here, and the number that would spend the necessary money to go to England would be very few.

(General Giffard.) He favoured the suggestion that successful candidates in India should be sent Home for 2 years. He realised the political difficulty of excluding them from the Home recruitment but that could be met by saying that, the military service being largely of British troops, the Government needed 50 per cent. of British officers.

(Mr. Hignell.) Supposing there was a separate civil service and separate military service, there must be a connection between the two, otherwise you could not provide for your military reserve. On the other hand, if you provided for your military reserve, the civil service in India would be an inferior one, and would not attract the best officers. He was against recruiting a special Imperial civil medical service, but would continue the provincial civil medical service on its present lines. If it were decided to have two or more separate services, he would organise the civil medical service on a provincial basis rather than on an Imperial one. He would not have an Imperial medical service.

(General Hendley.) He would give the officers whom he sent to England for 2 years their military pay, and send them as commissioned officers, granting them free passages.

He would not give Anglo-Indians, who were recruited among the 50 per cent. candidates in India, any special advantages, unless Government chose to give them a few scholarships. He would let them take their chance with the Indian. If they found any promising Anglo-Indian boy, he could be given a scholarship or could compete for one in any medical college.

With only fifty per cent. of Europeans, the medical services of the provinces would not be quite as efficient as now; but still would be up to a fairly high standard.

Government was prepared to make it a condition that assistant surgeons should go into military employ for the first year or two of their service; but they were not enthusiastic about it. The experience they would gain would undoubtedly do them good, but they would be less provincial than otherwise. He would not like to hazard an opinion as to how it would affect them professionally, but he thought it would improve their minds on general grounds.

(Major Cramer Roberts.) He could not venture to say whether the Local Government would be likely to object to any scheme that would involve extra expenditure; but he had no doubt that the Local Government would be willing to take its share of any extra expense, in the interests of the community. He could not, however, commit his Government to any statement on that score.

His Government would not be inclined to take on more men, in order to release others for periods of training, on the ground that it would tend to dislocate civil work, not merely on account of expense. The expense would, however, be a serious consideration.

(General Hahir.) An intimate relationship between the civil and military, through a war reserve, should be continued. With regard to the question as to who should be at the head of the service, he saw no objection to the present arrangement; as an alternative you might have the Director General as the head of the whole service. He did not, however, see any objection to the Director of Medical Services being the head of the military side and the Director General on the civil.

There would be no difficulty in finding employment for Indians in his 50 per cent. local recruitment scheme, as the army was half Indian, and in course of time would be more Indian than British.

He was not sure that you could rely upon the private practitioner as a civil reserve to take the place of the assistant surgeon who was sent on active service; but the private practitioner was the only man they had.

He agreed that the medical education for students in India was incomplete, because they never had the material as they had at Home for gynaecology or medicine, nor had they the same advantages in seeing *post-mortem* examinations. On the other hand, they saw more of medico-legal *post-mortems* and of tropical diseases. Every country had its advantages and disadvantages. The medical education which students received in Lucknow was as good as the average at Home, not as good as the best nor as bad as the worst. No arrangements could be made to complete the medical education of students in gynaecology, on account of the prevalence of the purdah system in India. In the Lucknow College they paid low class women to come in and be treated, as well as their children.

He would favour the gradual elimination of the military assistant surgeon class by employing them in other ways, such as quartermasters in hospitals, jailers in central jails, deputy superintendents in jails, and lunatic asylums, etc. He would get rid of them gradually. He would stop recruiting further for them. He would have no objection to the establishment of a corps of nurses, clerks, etc., similar to the rank and file of the Royal Army Medical Corps for the domiciled community, if you could get them to enlist, but he doubted if they would.

Independent practitioners had done the work of the Indian Medical Service officers during the war, fairly well, but not as well. They had not been trusted with running the classes in the medical colleges, but had got Indian Medical Service officers for that, and selected civil surgeons.

Under the scheme that he proposed of sending students Home for a 2 years' training, they would come

25 February 1919.]

The Hon'ble Colonel C. MACTAGGART.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

back at 27 or 28, which was the limit at present for admission to the Indian Medical Service.

He saw no objection to officers being sent for 5 years to the military side in relays. Military experience was of use to an officer, and such officers were better than those they had at present in civil.

The reduction of Indian Medical Service officers in his province would certainly interfere with the development of medical work. He had not suggested reducing them, but increasing them by doing away with the military assistant surgeon.

If they had to raise a reserve for the military, he would find no difficulty in employing an increased number of Indian Medical Service officers by doing away with the military assistant surgeon.

Lieutenant-colonels should revert to military duty or remain permanently in civil after 18 years' service. Supposing a large number elected permanently for civil, it would be better for military officers as they would

get their promotion quicker. The proportion of officers in civil employ, however, would be smaller than now. Some sort of limitation could be devised when the difficulty arose in regard to securing equilibrium of the two services.

He strongly opposed the idea of civil assistant surgeons and sub-assistant surgeons being under district boards.

With regard to commissions for sub-assistant surgeons, they should get commissions from the day they joined. They would not get recruits for the military service unless they gave in on this point. The sub-assistant surgeon had served for 5 years as a student and had more education than the average jamadar and was also getting as much pay as the average jamadar. As for the objection that he had no power of command, the same would apply to the commissioned medical officer.

THE HON'BLE SAIYID WAZIR HASAN, Advocate, Judicial Commissioner's Court, Lucknow.

Written statement.

Being a lay man and not having had any experience of the working of the present organization of the medical service in India I am placing my views before the Committee with a certain amount of hesitation. I also feel that the utmost that I can do is to offer my observations with regard to the general policy underlying the idea of reorganization of the medical services. I have carefully considered the schemes denoted as A, 'B,' 'C' and 'D' from that point of view and have arrived at the following conclusions :—

1. On general grounds I am quite clear in my mind that the establishment of a unified medical service for the whole of India is not only extremely desirable but essential, both on the ground of efficiency and uniformity. The dual system of the medical service in India at present existing had, in my opinion, not led to desirable consequences. There has, I venture to think, always existed a certain amount of discontent among the members of the Indian Medical Service as distinguished from the Royal Army Medical Corps. The cause for such a discontent is not far to seek. The highest appointments carrying with them the status and the largest emoluments are generally held by the officers of the Royal Army Medical Corps.
2. I am of opinion that the Royal Army Medical Corps should be entirely disconnected with India and should exist merely as supplying the needs of the Empire as a whole. It follows that we should have a separate Indian Medical Service to meet the needs both of the army and the civil population of the country.

Out of the four schemes mentioned above, I should have been prepared to support scheme 'C,' but for a very fundamental defect in it, which I am going to notice presently. The scheme proposes that "there should, therefore, as at present, be two medical services (a) the Indian military medical service, (b) the civil medical service." This division *per se* would have commended itself to me but it ignores, perhaps unconsciously—if I have understood the scheme rightly, that it is only through the connection with the military medical service that an Indian enters the commissioned ranks in the army, a privilege which I strongly emphasize. The disconnection between the civil and military medical services will close the door hitherto open to an Indian to acquire the rank of a commissioned officer in His Majesty's army if he enters the civil medical service. This feature clearly militates with the aspirations of the Indians and is, to my mind, a very serious drawback. Time has certainly come when we should be prepared to advance and encourage the

legitimate aspirations of Indians rather than take any step which might have the tendency to thwart them.

3. Having proposed the necessity of a unified medical service for India and having expressed adversely against the separation of the civil medical service from the military medical service, I am inevitably led to the conclusion that the higher grades of the proposed unified service should essentially be military.
4. The question which now arises is how to meet the medical needs of the civil population and of the local governments as well as of the Government of India. The answer to that question follows from what I have stated above. I now proceed to state it in a somewhat detailed form.

All persons qualifying themselves for medical services should first enter the army and serve there for a reasonable period say between three and five years. On the expiry of that period they should be given the choice of serving on the civil side of the service to which they should be bound to adhere for a fairly long period, say fifteen years, retaining the military rank which they hold at the time of their admission into the civil side and continuing to gain promotion in the same during the continuance of their service on that side.

5. I venture to think that the proposed transfer of officers from the military to the civil side will yield a fairly large number of medical officers and such officers will constitute an effective reserve in the case of emergency as hitherto. The lower grades of civil medical officers, for instance civil assistant surgeons and sub-assistant surgeons, will constitute another reserve, who can be mobilised in case an emergency arises for the same. If necessary their obligation for being mobilised for emergency purposes may be made a *sine qua non* of their service. These officers when so mobilised into an army may be given the Indian commissioned ranks suitable to the positions which they hold in the civil medical service.
6. The relation existing between the Indian private practitioners and Government medical services would not, I venture to think, in any way be affected in case a unified service as proposed is established. I am unable to accede to the suggestion that the private practitioners could, in any manner, be formed into a reserve. Yet they are not without a material utility to the Government in cases of emergency. They can readily take the places as they did during the present war time, of such of our medical officers and

25 February 1919.]

The Hon'ble SAIYID WAZIR HASAN.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

men as may be mobilised for the purposes of a war, I would, therefore, treat private practitioners as constituting a civil rather than a military reserve.

7. The transfer of officers of the Indian Medical Service from the civil charges to the duties of war has certainly, in my opinion, though only to an extent, and not wholly, resulted in the efficiency of the medical service. The usual work has, however, been carried on without much apparent difference.

8. It is an undoubted fact that private practice of the Indian Medical Service officers in civil employ has suffered an appreciable decline. This is mainly due to the fact that a respectable class of duly qualified private practitioners has grown up and is steadily growing.

9. It now remains for me to offer my opinion on the system of recruitment for the proposed unified service. I recommend that competitive examinations to qualify for admission into the service should be simultaneously held in England and in India and the results of each of the examinations should supply 50 per cent. of the total number required. It may be that the examinations held in England should be restricted to Europeans only while those held in India be open to Indians and Anglo-Indians only. I would, however, insist that the candidates selected in India should be required to go to England for further study and experience for a period of two years. This proposal I strongly recommend for favourable consideration of the Committee. It will be a genuine response to the aspirations of His Majesty's Indian subjects and yet it would not, in my humble opinion,

in any measure affect the efficiency of the service. I venture to think that the concessions suggested above will create a wave of gratitude in the country as a whole, which will be a material asset in the hands of the Government. It is just as well to face and solve these problems rather than to shirk them.

It is wholly beyond me to say as to whether the scheme which I have ventured to submit will meet with the approval of the War Office, but I venture to think on broad principles that it would meet the needs of the army in India.

I consider that this scheme will attract a good stamp of recruits and meet the demands of professional opinion in England and in India. This scheme will meet the needs of the civil administration in India, and will provide a sufficient and efficient military reserve.

I have no specific suggestion to make as regards the provision of a special department for research, but if the establishment of such a department is deemed necessary I would suggest that it should be Imperial that is, all-India and not local.

In the end I desire to say that I was a member of the Committee of the United Provinces Legislative Council appointed by His Honour the Lieutenant-Governor under Rule 13 of the rules for the conduct of business to consider the proposals contained in the Resolution of the Government of India on local self-government (no. 41, dated, May 16th, 1918). The Committee has submitted its report to the Government of the United Provinces and therein I have supported the view that the lower grades of the medical services ranging from civil assistant surgeons and downwards should be placed under the control of the local self-government. My opinion expressed in this memorandum should be treated subject to that reservation.

THE HON'BLE SAIYID WAZIR HASAN, called and examined.

(President.) There should be one unified Indian Medical Service to meet the needs both of the army and the civil population of the country, and it should be recruited on the basis of the needs of the army with a reserve in civil employ. All qualified persons should first join the army and should then after some time be transferred to civil employ at their option. The service should essentially be military. He was opposed to the idea of having a separate civil medical service.

Private practitioners could not be formed into a war reserve, yet they were not without material utility to the Government in cases of emergency. They should form a civil reserve and should take the place of medical officers who may be drawn away for military purposes.

A respectable class of duly qualified private practitioners had grown up and their number was steadily increasing. In the case of serious illness in his family he usually sent for the civil surgeon.

Recruitment for the unified service should be by simultaneous competitive examinations held in England and India, 50 per cent. of the total number to be recruited in each country. The Indian candidates should be selected in India but should be required to go to England for further study and experience for a period of two years.

The lower grades of the medical services, ranging from civil assistant surgeons downwards, should be placed under the control of local governing bodies. This had been recommended by a committee of the Legislative Council appointed to consider the question of local self-government.

The number of Muhammadan medical practitioners was on the increase and their number at present was much larger than in previous years. The medical profession was getting more popular on the whole.

(General Giffard.) There would be no difficulties in the way of holding examinations both in England and in India. With regard to the suggestion that it would not be possible to get the same class of patients for the students in India as in England he did not believe that

this would in itself lead to a difference in standard. No doubt the examiners for practical examination would have to be different and the clinical cases for the students would be different but this should not affect the standard. So far as the written papers at least were concerned they would be the same in both the places. In order to avoid the telegraphing of papers as they would be out in India 7 hours before they would be out in England it would be best to depart slightly from the meaning of the word "simultaneous" and to regulate the time for the examination so as to avoid this contingency. He did not attach much importance to the difficulty that students in one place would be working in the heat of the day and the others at a more suitable time.

By the suggestion to place lower grades of the medical services under local governing bodies he intended that they should be placed under the district boards except in the case of large towns. They would not be in Government service but in the service of the boards. It might be that district boards in some parts of India were very poor and their cadre small, and doctors might have to serve in places far away from the centres of civilization. These considerations, however, did not arise in the case of the United Provinces, and the committee referred to above had provided for extra money by additional taxation. They had fixed the standard for taxation according to profession and other things. In order, however, to meet the difficulty that assistant and sub-assistant surgeons would not be prepared to go to bad districts, it was proposed that there should be a divisional council which should regulate the question of transfer, promotions, etc.

(Mr. Hignell.) Under the above schemes there would really be divisional cadres both for the Public Works Department and for the doctors. These people would be liable to transfer from one district to another within the division.

(General Hendley.) The opinion expressed by him to the effect that military rank was an attraction to

25 February 1919.]

The Hon'ble SAIYID WAZIR HASAN.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

medical men and an inducement to them to join the Indian Medical Service had the support of young men who were being educated as doctors, as well as those who wished to enter the profession. He was not sure about the opinions of those who had grown old in the profession, but so far as the young men were concerned they held that view. If the attraction of military rank was retained for the civil medical service, it would attract a better class of men than if it were taken away.

The Indian Medical Service assisted by private practitioners had met the needs of India. A combination of the Indian Medical Service and the private practitioners was a good one for this purpose. If more Indians were admitted to the Indian Medical Service it would not require much improvement.

He was not prepared to accept the system of granting scholarships to Indians to proceed to England to qualify for the Indian Medical Service in place of the system of simultaneous examinations, as under the former the door would not be so wide as under the latter. In the

former system certain limitations would have to be placed as to who should be entitled to get the scholarships, what their qualifications should be and so on. This system would not satisfy the aspiration of Indians, and all that was required was to fix the standard of qualifications and no restrictions beyond that were called for.

(General Hehir.) Scheme 'C' militated against the aspirations of Indians in so far as it contemplated the separation of the civil and military medical services. He understood the scheme to mean that there would be a complete separation between the civil and the military services. He admitted that the separation existed even now but he was opposed to it. He was of opinion that in the beginning it should be an entirely military service and later on it should be left to the choice of those who were in the service to get transferred to the civil side. The scheme as he understood it put a sharp line between the civil and military so as not to allow the civil to enter military and get the rank. The recruitment for each of the two branches was separate under the scheme as he understood it.

LIUTENANT-COLONEL W. YOUNG, I.M.S., Civil Surgeon, Cawnpore.

Written statement.

Question for service officers.

1. Most of my service has been in the civil department. Out of 26 years, I have spent nearly 24 years in the United Provinces, with an interval of about six months on military duty during the Tirah Campaign. My first two years' service was nominally civil, but in reality semi-military, with a Battalion of Military Police in the Lushai Hills.

2. My chief complaint has been, in my earlier years, of frequent transfers. In 5½ years I was transferred 12 times. This is ruinous financially.

I have also had ground of complaint with regard to Railway appointments, and also with regard to recall from leave out of India. I have had leave Home three times, and have virtually been recalled twice, though the last occasion, being due to the war, is not a ground of complaint. Yet another ground of complaint is a financial one in that as a civil surgeon of 26 years' service, I can only draw to-day, as civil furlough allowance, the same rate which I was able to draw at six years' service.

3. As a rule my relations with the officers of the Royal Army Medical Corps have been most cordial.

4. Any grievances or friction between the two services can at once be removed by the creation of a unified service.

5. I suggest as the limit of service to be fixed for:—

- (a) transfer from military to civil employ—5 years' service,
- (b) transfer from civil to military—20 years' service.

Questions for witnesses.

Almost the whole of my service has been on the civil side. I do not in consequence feel myself qualified to criticise the organization of the Royal Army Medical Corps. On the civil side the chief defect, in my opinion, is the fact that the Director General does not have direct access to Government. Not being himself a Secretary to Government all his suggestions have to pass through the hands of Under Secretaries and Secretaries, with whose notes he may or may not agree. The Inspector General of Civil Hospitals is nominally in a similar position, but I understand that as a rule he is freely consulted by the local government.

I do not agree with any of the schemes 'A,' 'B,' 'C' and 'D' in their entirety. Scheme 'A' necessarily excludes Indians from joining the superior grade of the service, and they would naturally resent their position in an auxiliary corps with its implied inferiority.

Scheme 'C' with modifications appears to me to offer good prospects of a well organized and efficient unified

service, and would do away with the friction and differences inseparable from the existence side by side of two distinct services whose duties from time to time are bound to overlap. Such a unified service would also ensure greater efficiency amongst Assistant Directors of Medical Services of Brigades, as each officer would necessarily be fully acquainted with the management of both British and Indian sections of station hospitals, and with the rules and regulations which apply respectively to British and Indian troops. This scheme places all its officers of the superior grade, whether European or Indian, on an equal footing, and does not delegate the latter to an auxiliary corps. It also provides for the officering of a due proportion of civil appointments by officers of the superior grade, and not by a class of officer carrying only relative or temporary rank as suggested in scheme 'A.' By the formation of the unified service into a complete corps it would, I think, efficiently meet the needs of the army in India.

The question of recruitment for the new unified service, after its initial formation, by a fusion of the Royal Army Medical Corps in India, to the extent of the willingness of officers of that corps to transfer, with the Indian Medical Service, requires some consideration.

Political changes are taking place in India and the Indian is demanding a greater share of the appointments in the higher grades of the services, as well as a greater share in the administration of the country, and there is no use shutting one's eyes to this fact.

It is a distinct hardship for an Indian medical graduate to have to proceed to England to compete for the higher grade of the medical service, with the possibility of failure when he gets there. I would suggest that examinations be held simultaneously in England and in India, and that successful Indian candidates should then proceed to England for two years for professional as well as social experience, and that while there they should produce evidence of satisfactory practical training, especially in midwifery and diseases of women and children, a direction in which the present medical training in India is distinctly weak and likely to remain so for a very long time.

I am not in favour of the retention of the military assistant surgeon of the European and Anglo-Indian class. As at present educated his qualification is not registrable in England. If it were improved he would become dissatisfied with his subordinate position. On the civil side he is thorn in the side of the better qualified civil assistant surgeon, who may have to serve as assistant surgeon in a district in which the civil surgeon is a man of inferior qualification. The military assistant surgeon on the civil side occupies districts which could otherwise be held by officers of the superior

25 February 1919.]

Lieutenant-Colonel W. YOUNG.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

grade thus adding to the strength of the officer reserve. The place of the military assistant surgeon on the military side could probably be equally well filled by well trained military sub-assistant surgeons.

I also disagree with the proposal in scheme 'C' to include amongst executive officers, qualified Europeans and Anglo-Indians as an uncovenanted service. In the past this has not been a success and is quite unnecessary. Such members of the community could obtain entrance into the service through either the English or the Indian portals.

I do not approve of the periodical reversion of civil surgeons to military duty. This will cause very great disorganization on the civil side and would, I am sure, be strongly resented by provincial governments. If it be ruled that no member of the superior service be eligible for civil employ under five or six years' service, this will ensure each officer obtaining a thorough acquaintance with military service. Besides causing great inconvenience to civil administration a reversion to military employ every five years will seriously interfere with leave on the civil side.

In my opinion civil assistant surgeons, and probably also civil sub-assistant surgeons, should undergo 6 to 12 months' military training before beginning their civil duties. This, in addition to improving discipline, would enhance their value as reservists. I consider that their service conditions should as a matter of course include liability to military service up to not less than 15 years' service.

I cannot agree with the suggestion that officers on the civil side should be ineligible for promotion beyond the rank of lieutenant-colonel. The duties of administrative medical officers of provinces are heavy and responsible and his position in the civil administration demands that he be of rank not below colonel. Combatant officers in civil employ are not deprived of their promotion and I certainly do not see why medical officers should be.

I am prepared to concede the point that senior officers in civil employ should be eligible only for civil administrative appointments, but these appointments should be reserved for them.

2. It is hard to say whether scheme 'C' modified as I have suggested would commend itself to the War Office. I do not see that that office could consider it as other than an efficient organization. In my opinion it would meet the needs of the army in India.

3. I consider that this scheme, if accompanied by suitable rules as to pay, pensions and leave, and absence of irritating restrictions regarding private practice, would attract a good class of recruits and meet the demands of professional opinion in England and in India.

4. I am not in a position to make any statement as to the result of the withdrawal of European medical officers from charge of troops. As regards civil districts and jails, I believe there has been some effect on efficiency. This must necessarily follow when a superior class of officer is replaced by one whose attainments are not up to the same standard.

5. The scheme modified on the lines which I have suggested will I think meet the needs of the civil administration in India. These would necessarily be affected by the withdrawal of officers on the occasion of war on a large scale. This is inevitable, and the situation would, as during the recent war, be loyally faced by local administrations.

6. The scheme would provide a large and readily available war reserve for military purposes. This reserve could be supplemented to some extent by the offer of temporary commissions during the war period, with due regard to the fact that the only civil reserve available is the private practitioner. A Home reserve might add slightly to the number of officers available.

7. I consider it advisable to have the regular reserve for war previously trained to some extent in military work. This is provided for in the scheme. With the exception in the first instance of those absent from India on leave, the members of the reserve should be present in India.

8. I have no personal knowledge as to the value of the Indian Medical Service reserve (civil side) during the war as a whole, but the demand from civil administrations for these officers appears to be an evidence of their usefulness. In the cases of individual officers of the civil side who have been recalled to military duty and whom I know personally, I have no reason whatever to believe them other than thoroughly efficient.

9. I have incidentally dealt with this point under question 1. I would suggest equal recruitment in England and India.

10. Study leave is a misnomer. It is not leave and should be termed "Study deputation" or some equivalent term. As far as I know the rules extant provide suitably for it, but it should not be regarded as an alternative to leave properly so called.

11. I consider that there is a great need for very considerable enlargement of the present special department for research. India is in this respect a trustee of humanity, and should do all in its power to fulfil its trust. The establishment of a considerable department of research within the service would add considerably to its attractions. Such a department in times of need could also supply a certain proportion of its personnel to the reserve.

12. In the majority of stations private practice as such has almost entirely disappeared. A small amount of consulting practice alone remains. The reason for this is the very great increase in competition owing to the influx into the cities of trained medical practitioners, the product of Indian medical schools and colleges. These practitioners can afford to accept small fees. To some extent private practice has been affected by the resort to hospitals of well-to-do people. Another important factor is the want of time for practice occasioned by the steadily increasing amount of official work. Indian patients, when they require a doctor insist on his attending at once. To them all their cases are urgent. Failure to comply immediately with a request for attendance inevitably leads to loss of practice.

Special questions.

In my opinion the demand amongst Europeans for European medical attendance on themselves and their families is based partly on racial predilection and partly on the comparative professional merits of doctors educated entirely in the United Kingdom and those educated partly or entirely in India.

2. Europeans in stations where only Indian medical men are available have, I believe, on the whole been satisfied with their treatment in minor complaints, but in cases of serious illness have sought the aid of European doctors in other stations.

3. I do not feel myself in a position to answer this question.

Questions regarding assistant surgeons and sub-assistant surgeons.

1.

2.

3. Now that better pay has been sanctioned, I believe, the conditions of service to be satisfactory.

4. It is impossible for a province to supply assistant surgeons and sub-assistant surgeons for military work without a serious dislocation of the medical and sanitary services, but in times of stress I do not think that local governments would raise objection on the point. The number available could be very considerably augmented by making liability to military duty up to say 15 years' service a condition of appointment.

Owing to the withdrawal of men for military duty during the war it has been necessary in the United Provinces to man a very large number of fixed and travelling dispensaries with selected compounders. One cannot expect the same degree of efficiency from such men.

5. Yes, up to 15 years' service.

6. Yes, I do not consider any change desirable.

7. I have little acquaintance with the military sub-assistant surgeon except in my capacity as an examiner

25 February 1919.]

Lieutenant-Colonel W. YOUNG.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

at the Agra Medical School. I consider that their standard of preliminary education requires raising.

8.

9.

10. No, these officials have as much work as they can do in their civil hospitals which are already very much understaffed.

11. They should be available as reserves for military duty, and the monetary penalty under their bond should be raised.

12. I do not consider from what I have seen of the military assistant surgeon in general that he is at all necessary. He appears to do the work of a dispenser and quartermaster. He does not appear to be entrusted with professional responsibility. I should think he could be replaced by properly trained dispensers and quartermasters in a properly constituted Army Hospital Corps,

incorporated in the Indian Medical Corps. His work, as resident medical officer could be carried out by a properly trained sub-assistant surgeon.

13. In the civil department the military assistant surgeon was withdrawn for military duty. A few retired men were re-employed in the Jail Department.

14. No, he would be a redundancy and an anachronism.

15. As at present educated I do not consider he should be recruited further. If educated to a qualification registrable in the United Kingdom he would probably refuse to be recruited.

16. This is covered by the last sentence of my reply to question 15.

17. He would then probably compete for the Indian Medical Corps.

18. No, I propose to abolish him.

LIEUTENANT-COLONEL W. YOUNG, called and examined.

(President.) Witness had been stationed at Cawnpore for the past 11 years. His private practice there was entirely consultant. It had decreased 75 per cent. This decrease was due to the increase in the numbers of private practitioners; moreover, people were not disposed to pay Rs. 16 for a visit when they can get it for Rs. 2. Only in serious cases was civil surgeon called in. The ordinary Indian pays no attention to the qualifications of a doctor, so long as he gets a doctor.

(General Giffard.) He would favour simultaneous examinations being held in England and in India. The approved candidate who has passed in India should be sent to England for training instead of going into the service at once. The candidate so going would find himself junior to others and to obviate this, some concession in lieu should be provided.

(General Hendley.) He would raise no objection to short terms of military training for civil surgeons. This could be done somewhat on the system of territorial training in England.

There was only one civil assistant surgeon employed in Cawnpore and he was on the staff of district hospital at headquarters. He thought that the hospitals were very understaffed. He would like to see an increase all round.

(General Hchir.) He admitted the possible utility of having an advisory board for selection of officers to various appointments, but personally he did not quite see the necessity for it.

He was satisfied with the present conditions of employment of civil surgeons. He thought that if the grievances in the Indian Medical Service with regard to pay, leave, etc., were removed a better class of men would be forthcoming.

If the conditions of service for assistant surgeons and sub-assistant surgeons were improved generally, he anticipated no difficulty in getting them to join the war reserve. He did not see how private practitioners could be included in the war reserve as they

usually took the place of assistant surgeons when the latter were recalled to military duty.

He had no knowledge as to whether the promotion of Royal Army Medical Corps officers over the heads of Indian Medical Service officers as a result of the war, was a grievance in the service.

He did not think that the education which a student got in the various colleges was complete. He could not quite see how the colleges could be improved for the better education of students. He thought this was impossible.

He was inclined to do away with the military assistant surgeon as there was no use for him. He suggested that they should be allowed to compete simultaneously for the superior service after they had gone through their college course. He would train them up to the standard necessary to obtain a qualification registrable in England.

He thought there would be no place for the assistant surgeon in a military hospital if the Royal Army Medical Corps were brought out to India and attached to such hospitals. The assistant surgeon should be eliminated from the military hospital.

He considered that after 28 years' service a lieutenant-colonel should get his pension of £700 a year.

He did not think that the independent private practitioner was capable of discharging the duties of a civil surgeon.

The prospect of research work in India would be a great attraction to young men joining the service. He did not think there was much scope for such work under present conditions.

(President.) There was only one independent European practitioner in Cawnpore and he has a very large practice. He had been there for 4 years. He was brought out by the syndicate of mills. He did all the mill work, and as he had been permanently stationed there the people had come to know him and they accordingly called him in when required. He also had a certain amount of practice among Indians.

LIEUTENANT-COLONEL E. J. O'MEARA, F.R.C.S. (Eng.), D.P.H. (Camb.), Civil Surgeon and Principal of the Medical School, Agra.

Written statement.

I would offer the following criticisms to the schemes 'A,' 'B,' 'C' and 'D':

- (1) The civil side of the service would appear to have received very limited consideration, this is a political error, as on the efficient administration and working of our civil hospitals, depends one of our main holds on the good-will of the people. And on this branch of the service, the attractiveness for European recruitment will chiefly depend, as apart from the question of private practice, or emoluments, it is only the civil side which offers professional inter-

est, and it is the enormous scope for work in all branches of the profession, which will always form the greatest inducement for the class of men required, to undertake an Indian career.

- (2) It would appear that the schemes have not taken into consideration the changes that must result on the civil side from the "Transfer part" of the Indian Reform Scheme.
- (3) The schemes have not taken into consideration the concentration of work at a few

25 February 1919.]

Lieutenant-Colonel E. J. O'MEARA.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

large centres which should result from the experience of the war.

- (4) It appears to be taken for granted that the number of officers required for these schemes will be forthcoming.
- (5) The increase in the peace proportion of officers from 1·2 to 3 per mille would appear to be unnecessarily high.
- (6) That the way in which the civil side is to provide the all important war reserve of officers is indefinite and not worked out in detail.

While I admit that the military side of this question must loom the larger in the report, at the same time I would submit that the civil side is the pivotal service on which the whole organization must rest for sustained proficiency in professional work and for attractiveness in recruitment.

I would therefore submit the following scheme for the reorganization of the civil side as the first step in the general scheme:—

Reorganization of the civil side.

That each presidency and province should organize its medical service into medical divisions, these divisions would roughly correspond with the revenue division but would depend on the facilities of communication by rail and more especially by road with the headquarter station.

At this headquarter station, would be a senior Indian Medical Corps officer, holding one of the residuum appointments, as defined in scheme 'B.' On the staff of this officer, and working directly under his control and orders, would be from 4 to 8 officers of the same service.

This "indispensable" staff would be responsible for the whole (1) medical, (2) preventive, (3) sanitary and (4) jail administration of the division.

The headquarters of each district in the division would retain its civil surgeon who would practically always be an Indian, under the administrative control of the divisional officer, it would retain a small district hospital and the usual district staff.

A general idea of the way in which the division would be worked is as follows:—

The divisional officer at divisional headquarters would gradually build up a large hospital for the treatment of all the more important cases in his division, with an efficient nursing staff, X-ray plant, pathological, bacteriological, and clinical laboratories, and a separate European hospital block.

The cases would be brought into headquarters by motor ambulances, from branch dispensaries or district hospitals. The divisional officer would have a sufficient number of these conveyances under his control, for the efficient working of his division, in some cases transport by rail, or in Bengal by boat would be necessary, but generally motor transport will be the quickest, cheapest, and best for the patient.

The divisional officer would thus always have at his disposal an officer he could send to treat or bring into headquarters a European officer or lady who disliked being treated by the district Indian civil surgeon, or to perform or assist the civil surgeon in performing an operation in the rare eventuality of the patient not being in a condition to remove to headquarters.

In the case of sanitation the divisional officer would immediately be able to deal with an outbreak of epidemic disease by at once concentrating a sufficient and organized staff, and this is one of the most important points of the scheme, as the present Sanitary Department is very rarely able to give a civil surgeon any assistance, and if it does make any attempt, it invariably arrives too late.

The district and central jail and asylum, if any at divisional headquarters, would be held by the divisional officer, through one of his assistants, the jails at district headquarters being held by the civil surgeons as at present. I am opposed to a separate jail service, as however useful these officers may be

from an administrative point of view, their services are of little use professionally.

This scheme aims at scraping all small hospitals, such as police, jail, railway, etc., not only at divisional, but also at district headquarters, these hospitals are always badly equipped and with the meagre funds available cannot be properly managed. At the police, jail and railway there should be only an out-door dispensary, and small detention ward, all cases being sent to the police or jail ward (under guard) in the district hospital, or if sufficiently important sent to divisional headquarters.

Branch dispensaries except in certain important towns would not have in-patient wards, but would draft their cases into district or divisional headquarters by motor transport and this meets one of the great difficulties to medical relief in the past, i.e., of getting patients to centres at which they can be operated on.

The divisional officer would also have a small medical store department under his charge, which would be supplied from one of the present medical store depots, and from which he would meet all annual and emergent indents within his division. This would result in a considerable saving in freight, bottles and packing and at the same time give greater efficiency. The sub-charge of this depot could be held by a sub-assistant surgeon or by a business manager such as a chemist's assistant.

The points of this scheme are:—

1. The 4 to 8 Indian Medical Corps officers serving under the divisional officer would always be an efficient and mobile reserve, ready for either military or civil emergencies.
2. This reserve could always be concentrated at any required place in any numbers, and with a minimum of disturbance to the civil administration, their place being taken by civil assistant surgeons.
3. There would be a constant interchange between the civil and military sides of the service, the military training thereby being frequently brought up to date.
4. That the officers of this reserve would be in the daily practice of their profession in all its branches, medical, surgical, or preventive, at the same time they would be able to specialize in one or more subjects.
5. That the scheme would receive less political opposition and be more in accordance with Indian public opinion, as it leaves the civil surgeoncies of districts to Indians with a very few exceptions.
6. Financially, the scheme would not be costly and would ultimately result in a saving by the abolition of the jail, sanitary and railway departments, and by concentration of funds on the district and divisional hospitals, which are at present wasted on numbers of small hopelessly inefficient institutions. Moreover, the number of officers actually working on the military side could be kept at or about 1·2 per mille instead of being increased to 3 per mille.
7. During the war when I have held charge of an asylum, a police hospital, two railway and two jail hospitals, and from time to time the visiting charge of two other districts, I have put this scheme into force in a modified way and found it to act satisfactorily.

Any scheme I think must provide for two not-transferable departments:—

- (i) Chemical Examiner.
- (ii) Research.

(i) *Chemical Examiners.*—These officers must be looked upon as "indispensable" and no part of the reserve, and it is advisable that they should not be Indian Medical Corps officers, or if belonging to that service should be permanently seconded.

The Chemical Examiner's department should deal only with medico-legal cases, the bacteriological work,

25 February 1919.]

Lieutenant-Colonel E. J. O'MEARA.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

water analysis and examinations under the Food and Drugs Act being done at the headquarter divisional laboratories, thus bringing this work directly under the sanitary administration, which in any case is a very necessary reform.

(ii) *Research*.—This question has been dealt with under "Replies to questions for witnesses."

Questions to be asked of service officers.

1. Five years in military service, and 16 years in civil.

2. Yes. (1) The Medical Department has no share in the government of the country.

(2) The present unsatisfactory organization of the department, and the urgent necessity for revision of its obsolete rules and regulations.

(3) The hopeless delay on the part of the Government in dealing with everything medical, with the result that when questions are ultimately decided the original circumstances under which the points arose have often completely changed.

(4) The insufficient pay, impossibility of obtaining furlough, and promotion to administrative rank at approximately the length of service obtaining in the Royal Army Medical Corps.

The promotion and retention of inefficient officers.

(5) The general attitude of Government towards the service, an attitude which will not in future be tolerated by the Home profession, and which if persisted in will entirely stop European recruitment.

3. Yes, but in the last few years have become less and less frequent, and can nearly always be got over by the exercise of a little tact.

4. Yes, unification of the service.

5. In accordance with the scheme which I have suggested I would recommend the transfer from:—

(a) Military to civil, and

(b) Civil to military, up to the rank of lieutenant-colonel, i.e., 20 years' service.

Special questions.

1. In the case of ladies, race is an insuperable difficulty, but there can be no question, that those doctors educated entirely in India, are comparatively ignorant of obstetrics, gynaecology, and diseases of children.

2. On the whole no, but there are some notable exceptions. The difficulty has been met by going to the larger centres, at which Indian Medical Service officers have been retained.

3. The service is a curious mixture of hopeless inefficients and some of the most brilliant men in the whole profession. Up to 15 years ago, the general impression at Home was that the service obtained those men who just failed to get on on the staff of their hospitals, or who had not the necessary capital to become consultants, but from that time on the stamp of men has rapidly deteriorated, except for a short time about 7 or 8 years ago, when a few excellent men came into the service. But even if the best men were obtainable, the present system must lead to inefficiency and deterioration, as there is no encouragement for good work, jobbery is rampant, the inefficient and efficient get the same promotion, and the only stimulus to keeping up to date, and getting good results, is the knowledge that it leads to an ever increasing range of private practice.

Medical Stores Department questions.

1. (a) Annual.

(1) The tinctures and acids, by a firm selected by the district board generally on the recommendation of the civil surgeon.

(2) All other drugs from Messrs. Burgoyne and Burbidges of London.

(b) Emergent indents.

From Messrs. Butto Kristo Paul and other firms in Calcutta or Bombay.

2. With the sub-assistant surgeon in charge of the dispensary who submits his indents to the civil surgeon, and personally I check myself every item in each indent as I find it a useful way of ascertaining the extent and methods of treatment in each dispensary.

I consider there would be a considerable reduction in cost, freight and especially of packing if all district board and municipal dispensaries were supplied from store depots, but this could only be done economically from a divisional store depot to which the indenting dispensary would send its empties for refilling.

In any scheme of this kind, full consideration should be given to the possibilities of local production in India. Quite half the drugs in the British pharmacopœia are indigenous in this country, and the majority of the remainder could be cultivated under scientific supervision.

A beginning might be made by the establishment in certain stations of medicinal farms, the old Company *baghs* now mostly dilapidated and neglected might be utilised, the farms to be cultivated by the Horticultural Department and scientifically controlled by the Botanical Department.

This would enable research work to be carried out free from the possibility of adulteration, wilful or accidental, and on fresh material, much of the discredit of Indian medicines in the past being due to the age of the stock and defective methods of storage.

These gardens would ultimately lead to depôts which could be retained by Government or leased to reliable manufacturing firms.

3. The working of the Medical Store Depot up to the time of the war was most unsatisfactory, since when it has steadily improved but is still extremely slow in dealing with indents. I consider that the depôts should have a business manager in charge and not a senior Indian Medical Service officer. This manager to have at least five years' experience in a large firm of manufacturing druggists at Home. The depot to be frequently inspected jointly by the civil administrative medical officer of the province and the Assistant Director of Medical Services of the division in which it is located.

Replies to questions for witnesses.

1. The present organization does not make the best use of the services available.

The schemes 'A,' 'B,' 'C' and 'D' do not commend themselves to me for the reasons detailed in the alternative scheme I have proposed.

2. I can see no reason why the alternative scheme should be opposed by the War Office as it meets the needs of the army in India and has the great advantage of constantly keeping up the military training of the whole service, with the exception of the small minority of the "indispensables," while at the same time keeping the service in the constant practice of the profession in all its branches, or of allowing specializing under the best possible conditions.

Further even the services of the "Indispensable" would not be lost to the military side of the service, as their extended knowledge of the country and people should make them far more valuable as consulting surgeons and physicians [scheme 'A,' para. (j)] than consultants imported from England.

3. I consider the scheme I propose would attract a good class of recruit and meet the demands of professional opinion in England and India and of public opinion in India.

4. I am not qualified to speak as regards troops, the withdrawal of European medical officers from the civil surgeoncies of the smaller districts with a few exceptions has not been a serious disadvantage.

The central jails suffered seriously at the commencement of the war from lack of discipline.

5. Yes, and far better than the present organization. It would not be seriously affected by war on a large scale, as men of the assistant surgeon class, either

25 February 1919.]

Lieutenant-Colonel E. J. O'MEARA.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

private practitioners or temporary men, would be recruited to fill the places of the Indian Medical Corps officers removed from the staff of the divisional officer.

6. It would give an ample and very efficient military reserve, which would not require supplementing.

7. Yes, and apart from furlough, this reserve should always be actually present in India, a reserve brought from any other country would have the serious disadvantages of not knowing professional conditions in this country, the language, habits or customs of the people.

8. I am not qualified to give an opinion, but judging from reports no attempt was made at the beginning of the war to utilize the officers in accordance with their special qualifications.

9. A competitive examination in England followed by a course of six months' training at Millbank and Aldershot, followed by a second examination to determine the place of each man in the batch, and to exclude any undesirable.

10. The whole question of leave has been such a farce since I have been in the Indian Medical Service that it is difficult to give an opinion, as if leave has not been closed for military reasons it has been closed for civil emergencies such as famine and plague. It is probably advisable to have special study leave, but all those men who are keen on their profession and have private practice to keep up will always bring themselves up to date when on ordinary furlough. The study leave rules should not be too rigid as regards special courses, but the allowances should be given to any man on ordinary furlough who can produce definite evidence that he has attended the practice of a hospital and endeavoured to bring his general knowledge up-to-date.

11. The department of research should be a special department unconnected in any way with either the civil or military service and directly under the Director General, Indian Medical Service. It should be recruited, if necessary, from the profession or allied professions of all nations and scholarships or other remuneration offered in order to obtain the world's best workers.

Officers of the Royal Army Medical Corps, Indian Medical Service or unified corps would not necessarily be excluded, but if an officer showed special qualification for this work he would be seconded.

12. On the whole it has declined. The reasons are:—

- (1) Political opposition to the European.
- (2) Improvement in the qualification of the Indian assistant surgeons and practitioners.
- (3) Decline in the qualifications of civil surgeons more especially in the junior grades.

But in the larger stations there will always be practice for men who are well up in their profession, and have tact in dealing with Indians and their customs, and I am inclined to think this outlook will improve rather than decline.

Answers to questions regarding Assistant and Sub-Assistant Surgeons.

I am not in favour of employing assistant surgeons on the military side of the service, they should be entirely employed on the civil side.

My personal experience of military assistant surgeons working under me as assistant to the civil surgeon is

that their professional knowledge is very limited. I am not in favour of continuing to recruit this class, but if it is necessary for political or other reasons to employ this community I should advise their being allowed to compete for the same appointments as Indian civil assistant surgeons.

I do not consider the Indian civil assistant surgeon suitable for any form of military employment. Their training and family connections render it impossible for them as a body to be an efficient war reserve, in time of war there will, however, be ample employment for them on the staff of the divisional officer.

Sub-Assistant Surgeons.

A.—MILITARY SUB-ASSISTANT SURGEONS.

After being principal of the largest medical school in India for nearly seven years, I have come to the conclusion that it is advisable to train military sub-assistant surgeons apart from civil and private students. As this class will shortly be given commissioned rank, and with the introduction of the station hospital system, it is essential that their sense of discipline and *esprit de corps* be improved, this could best be done by having one military medical school for the whole of India with an Indian Medical Corps commandant and adjutant and an adequate staff of drill instructors.

This class is now well paid, and will be perfectly contented if given commissioned rank, which is their right, and due if only considered from the point of their educational qualifications. If commissioned rank is not given there will be endless trouble and recruitment will stop.

I consider that they can adequately fill the position of resident medical officers and that there is no necessity of having any other qualified grade in a military hospital.

B.—CIVIL SUB-ASSISTANT SURGEONS.

Unlike civil assistant surgeons a war reserve must be formed of this class to reinforce military sub-assistant surgeons in time of war.

I think it will be generally admitted that during this war civil sub-assistant surgeons have given endless trouble about going on military duty, and when they have gone on service have been far from satisfactory. I attribute this to their training and would recommend that all civil sub-assistant surgeons be trained in a military school.

And that when they passed out they should be seconded for civil employment, thus forming an efficient military reserve that could be called up for short periods of training in military hospitals from time to time. There would be no practical difficulty in carrying this out, as during the last few years, the tables have been completely turned, and military employment is not only more popular but gets a better class of men, the applications being greatly in excess of the number of vacancies.

A clerical staff must be maintained in station hospitals, and sub-assistant surgeons relieved of all clerical work; in the past, their time has been taken up with making out returns, instead of attending to their professional duty.

LIEUTENANT-COLONEL E. J. O'MEARA, called and examined.

(President.) He had 5 years' military service and 16 years' civil.

He was in favour of having a unified medical service including the civil and military. He thought this was the only way of dealing with the question.

He would not divorce the military from the civil. The civil side must be the pivotal service on which the whole organization must rest for sustained proficiency in professional work and for attractiveness in recruitment. According to his scheme each presidency and

province would organize its medical service into medical divisions. These divisions would depend on the facilities of communication with the headquarters station. At the headquarter station there would always be a senior medical officer and on his staff he would have from 4 to 8 officers of the same service working directly under his control and orders. The divisional officer at divisional headquarters would gradually build up a hospital for the treatment of all important cases in his division, and these would be

25 February 1919.]

Lieutenant-Colonel E. J. O'MEARA.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

brought into headquarters by motor ambulances from branch dispensaries or district hospitals. The building of the hospital could be done by simply increasing the size of the existing hospital. He anticipated that this would probably take a little time, but he did not think that the expenditure involved would be very great.

His scheme aimed at abolishing all the minor hospitals such as those in jails, police and railway hospitals, etc., as these hospitals were always badly equipped and with the meagre funds available could not be properly managed. In time there would thus be an important hospital where there would be a staff of Indian Medical Corps officers serving under the divisional officer, and these would form an efficient and mobile reserve ready for either military or civil emergencies. The divisional officer would have a small medical store depot under his charge, which would be supplied from one of the present medical store depots.

He said that the recent increase of 33½ per cent. in the pay of Indian Medical Service officers was a satisfactory increase. What he required was more leave. He had not had any furlough except sick leave.

He did not think that Government gave medical questions the treatment they deserved.

If the present organization of the medical services continued it would lead to inefficiency and deterioration as there was no encouragement for good work.

The standard of efficiency of Indian private practitioners had gradually improved. They very seldom called in a civil surgeon in consultation. He had some private practice at Agra. He had been there for 7½ years and his practice was increasing in spite of political opposition.

The Agra Medical School was under his charge. Last year there were 724 students and this year 520. A great number has been taken in on account of the war. His normal number of military sub-assistant surgeon pupils was 72 in peace time. During the war he had taken up to 500. His staff consisted of 11 assistant surgeons and 3 sub-assistant surgeons. He was the only European. The school worked very well. The students had to be ruled very firmly.

There was a strike at the school 4 years ago. The only terms on which he (the witness) would readmit the strikers was unconditional surrender on the part of the students and this the students ultimately accepted, after nearly 7 weeks. There had been trouble from time to time but nothing to speak of.

On the whole discipline in the school was good. The demand for admission to his school was very great. The year before last there were 1,200 applications. For the military sub-assistant surgeon class alone there were 267 candidates who had passed the matriculation examination. The majority were Sikhs and Punjabis. He generally found that they were related to men who were serving in the army as combatant native officers. He would estimate the proportion of people from the Punjab at about ¾.

With regard to jail patients under his scheme he would have one ward in the divisional hospital reserved entirely for them, and have a police guard in attendance on them.

He was not prepared to admit the difficulty in combining the various hospitals; while he submitted that the saving to Government would be enormous in having one large institution.

(General Hehir.) He regretted that there was no course of physical training in his school as he was unable to get an instructor for the pupils.

He favoured the idea of an Advisory Board for the selection of officers for various appointments in the Indian Medical Service.

He would enclude civil assistant surgeons from the war reserve as he did not think they made efficient military officers. It was impossible to get them to volunteer.

He favoured the establishment of an Indian military college for the training of Indian students on the same lines as that at Millbank. He would, however, keep the research branch quite distinct from the college.

He agreed that the medical education given at present to medical students in India was incomplete and was capable of improvement. It was desirable to improve hospitals in order to give graduates a better education, without the necessity of sending them Home.

His personal experience of military assistant surgeons working as assistant to the civil surgeon was that their professional knowledge was very limited. He was not in favour of recruiting this class but if it was considered necessary, for any particular reason, to employ the Anglo-Indian community, he would suggest that they be allowed to compete for the same appointments as Indian civil assistant surgeons.

The popularity of the Indian Medical Service would never be regained even if the present discontent was removed. He thought that the service was absolutely done for.

Khan Sahib, SAHYID ZAHID HUSAIN, President, Provincial Sub-Assistant Surgeons' Association, United Provinces.

Written statement.

1. I have no personal knowledge.

2. Yes, I consider that study period would be important to my branch of the sub-assistant surgeons, (a) they should get a study period of 6 to 12 months during their service. This might be taken in any of the existing medical colleges. (b) Only those borne on the special war reserve should be sent to the Indian Medical Corps College periodically for a course of military training (*vide* para. 53, scheme 'C').

3. I think such appointments will be sought by military sub-assistant surgeons, but civil sub-assistant surgeons will not like this procedure, if good branch dispensaries and district hospitals are taken up by men fresh from the military department. I therefore suggest that they should first be posted to jail and police hospitals to learn civil duties for some time.

4. In the United Provinces, civil sub-assistant surgeons are already required to have passed the School Leaving Certificate Examination, before admission to the Agra Medical School. I think this is quite sufficient. Formerly a University Entrance certificate was required for admission into medical colleges, and many of the present Indian civil surgeons and assistant surgeons hold only this qualification. I

therefore suggest that this qualification should be considered quite sufficient for admission of a sub-assistant surgeon into a medical college. The School Leaving Certificate Examination is supposed to be superior to the University Entrance or Matriculation Examination. In this connection I suggest that the same preliminary qualification should be demanded from compounders who seek admission into a medical school.

5. The effect of demanding a security of money before commencing training will, in my opinion, not be good on recruiting. The class of people from which candidates for this service are recruited is generally poor. This practice in my opinion would also not be advisable on other grounds. As for example, during this great war many junior sub-assistant surgeons on being detailed for military duty had to go quietly as on the spur of the moment they could not manage to deposit the required amount to have their bonds cancelled. Whereas if before commencing training the money was deposited by their parents, many more would gladly allow it to lapse to Government and would resign office.

6. The bond now signed is not generally satisfactory as civil sub-assistant surgeons have in several

25 February 1919.]

Civil Sub-Assistant Surgeon SAIYID ZAHID HUSAIN.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

instances preferred to have it cancelled by payment of money and losing Government service rather than to go on military duty when called to do so. The reasons are probably as follows:—Civil sub-assistant surgeons become accustomed to easy life, home comforts and independent charge. Moreover, they find military duty not sufficiently attractive as regards work, rank, "izzat" and pay.

The remedy, in my opinion, will not be found in making the bond more binding but in improving the condition of military sub-assistant surgeons' service and formation of a special war reserve and periodical military training.

7. I have no personal knowledge.

8. I think all sub-assistant surgeons after passing from medical school should be enlisted as a special war reserve and should also undergo a course of military training. The sub-assistant surgeons of 15 years' service and over this period should not be available for military duties. Thus paragraph 30, scheme 'C,' would roughly apply in the case of such sub-assistant surgeons as have advanced in age and service. (Also *vide* paragraph 10, scheme 'A'.)

9. We are not satisfied with the present scale of pension. The reasons are that (a) we get no holidays, (b) the nature of duties is taxing and arduous, (c) we are disturbed at all times of day and night, (d) privilege leave and furlough, etc., are not obtainable in most cases.

I therefore suggest that pension be granted on the following scales:—

½ pay after 10 years' service	on being in-
½ pay after 15 years' service	validated by a
½ pay after 20 years' service	Medical
	Board.
½ pay after 25 years' service	without being in-
	validated by a medical board.

It should be optional however for a sub-assistant surgeon to work up to 55 years of age if he so desires.

10. It would be very desirable to have a scheme of pensions for widows and orphans of civil and military sub-assistant surgeons and contributions will be made willingly. I remember instances where the family of sub-assistant surgeons, who died of an infectious disease contracted in the discharge of their duty, was given pension by Government amounting probably to half the pay of the deceased. This, however, was limited to a few cases and should in future be awarded as a rule.

11. The following are the specific disabilities in my service which I desire to bring specially to the notice of the Committee:—

(a) The training we receive in a medical school for four years is not recognised even in a medical college of the same province, and the result is that we cannot advance in our knowledge and position.

I therefore suggest that men already in service should be required to undergo only one

year's further training at a medical college for graduating.

For future our course should be extended to five years and education in every respect raised to the standard required to obtain qualification registrable in the United Kingdom.

(b) We feel that promotions of our men to the rank of civil and military assistant surgeons should be made on a liberal scale and after 15 years' service a sub-assistant surgeon should rank as an assistant surgeon. The pay should be so regulated that a sub-assistant surgeon after 15 years' good service may receive the same salary as an assistant surgeon of the lowest grade does and subsequent promotions should be made accordingly.

(c) *Jail service.*—We should be directly under the medical officer and our relation with the superintendent should be that of an assistant or a deputy. At present a senior sub-assistant surgeon has to work under a jailor getting half his own salary, and if the jailor goes on leave he has to work under a moharrir getting Rs. 15 per mensem.

(d) The dispensaries are likely to be transferred to the district board and our men will be dismissed and punished by the same unprofessional body and inspection of dispensaries made by laymen. All this is exceedingly humiliating and injurious to our service and I know that the unanimous desire of my class of men is to let the condition of our service remain unchanged as far as it concerns appointment, dismissal, transfers, inspections, etc. If this is not practicable now, I recommend that our case should, on the above matters, be dealt with like that of an assistant surgeon, deputy inspector of schools, etc.

12. I have no special recommendations to make here excepting those already mentioned in reply to questions no. 4 and no. 11 (a).

13. I have no personal knowledge.

14. When civil sub-assistant surgeons are in military employ they should, in my opinion, be brought under the Indian Army Act as regards the wearing of uniform and other military privileges and disabilities and this should not adversely affect the service, provided they are made commissioned officers.

15. As already suggested there should be a special war reserve. After completing 15 years' service the men on the reserve list should no longer be available for military service as defined for civil medical officers in scheme 'A,' para. 10. The grant of a suitable allowance would be desirable. Conditions made on the above lines will not probably affect adversely.

Civil Sub-Assistant Surgeon SAIYID ZAHID HUSAIN, called and examined.

(General Giffard.) Civil sub-assistant surgeons did not like to go to military duty because service as military sub-assistant surgeons did not suit them. They had complaints as regards their rank and the family pension which was granted in the event of their being killed. It was not his intention to make it easier for them to break the bond and escape military duty by the recommendation made in para. 5 of his written statement, to the effect that parents of the students should not be required to deposit cash security before their sons commenced medical training. His intention, on the contrary, was to make it more difficult for them to do so, for if the parents had deposited the money in advance the sub-assistant surgeons when called on for military duty would not care whether it lapsed to Government and would refuse to proceed on military duty. If, however, instead

of a cash security being demanded in advance, the sub-assistant surgeon had to pay the money himself, or to get his property attached in the event of his refusal, he would have to proceed on military duty for want of money alone. Otherwise if he had not to pay he would be unwilling to proceed on military duty.

With regard to the question as to what steps were called for to make the civil sub-assistant surgeons realise that it was part of their duty to proceed on military duty, the tendency at present being to try to get out of it, he explained that as far as the bond was concerned it was not defective. Their main grievances were the want of proper rank, want of sufficient pay and want of proper provision for their widows and children in case of death, and if these grievances were removed it would have the effect of inducing these men to proceed on military duty. They

25 February 1919.]

Civil Sub-Assistant Surgeon SAIYID ZAHID HUSAIN.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

should be given Indian commissions, a little better pay and an adequate family pension.

(General Giffard.) The only difference between assistant surgeons and sub-assistant surgeons should be one of length of service. In fact it would be better to abolish the assistant surgeons and make them all sub-assistant surgeons though this designation should be changed. All should begin from the lowest grade and should be promoted to the higher grades after a certain period of service. All of them should have registrable qualifications and should have the chance of rising in after life and should not be doomed to remain as sub-assistant surgeons, as at

present, during the whole of their life. In his written statement he had suggested that after 15 years' service all sub-assistant surgeons should get the rank of assistant surgeon.

(General Hehir.) When civil sub-assistant surgeons proceed on military duty they should be granted Indian commission. They would be willing to join the family pension fund and it would be desirable to organise such a fund.

The grant of study leave should be compulsory periodically for the period during which a sub-assistant surgeon was liable to be called to military duty.

26 February 1919.]

Lieutenant-Colonel J. M. CRAWFORD.

*(The schemes and questions referred to by witnesses are contained in Volume III.)***At Lucknow, Wednesday, the 26th February 1919.**

PRESENT:

THE HON'BLE SIR VERNEY LOVETT, K.C.S.I., I.C.S. (*President*).

MAJOR-GENERAL G. CREE, C.B., C.M.G., A.M.S.
 MAJOR-GENERAL P. HEHIR, C.B., C.M.G., C.I.E.,
 I.M.S.
 MAJOR-GENERAL H. HENDLEY, K.H.S., I.M.S.
 THE HON'BLE MAJOR-GENERAL G. G. GIFFARD,
 C.S.I., I.M.S.

S. R. HIGNELL, Esq., C.I.E., I.C.S.
 LIEUTENANT-COLONEL A. SHAIRP, C.M.G., Indian
 Army.
 MAJOR M. T. CRAMER-ROBERTS, Indian Army.
 MAJOR A. A. MCNEIGHT, I.M.S. (*Secretary*).

LIEUTENANT-COLONEL J. M. CRAWFORD, I.M.S., Civil Surgeon, Benares.

*Written statement.**Answers to questions for witnesses.*

1. Most of my service has been spent in civil employment so I have some hesitation in putting forward my views on military medical organization.

As far as I have been able to observe the chief defects are due to a want of cohesion among the various personnel framing the medical services in India.

Like all branches of the British Army the Royal Army Medical Corps has made great strides in efficiency since the South African War, while the Indian military medical services, in comparison, appear to have merely marked time since then, and to bring the Indian Medical Services up to date so as to provide an efficient organization ready at all times for service in peace and war, the Indian Government will have to open its purse strings freely. Owing to financial stringency in the past I consider no military medical administrator in India has ever been given a chance to show what he could do.

The only possible cure for the present state of affairs is I consider to form a unified Indian Army Medical Corps.

The chief difficulty in the formation of such a corps is I consider in the officering of it, in devising a system that will do away with the present dual administrative control and provide openings for Indians as well as Europeans and satisfy the demands of both the civil and military Governments.

None of the schemes 'A,' 'B,' 'C,' or 'D' appear to me to put forward a suitable solution of the problem.

The existing system has in the past given rise to much friction and jealousy among officers, which has been much accentuated by the present war and there is a general feeling of discontent abroad among Indian Medical Service men, which is partly due to the wholesale fashion in which they have been superseded by Royal Army Medical Corps officers, due to the augmentation of the Royal Army Medical Corps at the outbreak of the war. As an example of this I mention my own case as compared with my contemporaries in the Royal Army Medical Corps. In 1914 I understand the Royal Army Medical Corps officers, who were at Netley with me, were promoted to full colonels shortly after the outbreak of war, they are now about 5 years senior to me, or to put it another way were promoted full colonels in less than 24 years' service, while I have now more than 28 years' service and still another year or so to serve before my name will be considered for promotion.

If such a state of affairs bears hardly on the senior officers how much more must it affect the junior ones.

The Royal Army Medical Corps do not admit Indians, and as I consider under existing circumstances it is essential that Indians be admitted to the new corps I suggest that the Royal Army Medical Corps be withdrawn from India.

The new corps might be officered as follows: -

- (1) Transfer all Indian Medical Service officers to it.
- (2) Permit Royal Army Medical Corps officers to transfer to it, provided they are prepared to take rank in it according to length of service, the same as officers of the Indian Medical Service now serving (this I consider most important).
- (3) Selected officers from among those holding temporary or honorary temporary commissions in the Indian Medical Service.

I would give all officers the same rate of pay and allowances as Royal Army Medical Corps officers get for serving in England, with, in addition, a suitable foreign service allowance (graded according to rank or length of service) for European officers serving in India or overseas to compensate such officers for a life of exile with all the attendant heavy expenditure involved in connection with service in a foreign land, such as family separation, education, passages, etc.

Indian officers would draw this allowance while serving overseas or undergoing training in England.

Indian officers at present in the Indian Medical Service to draw the same pay and allowances as European officers.

I do not think there would be any indignity put on an Indian officer, by asking him to serve in India on the same rates of pay as a British officer gets for performing similar duties in England.

The pensions at present in force should be reconsidered on a more liberal scale.

2. I think the above rough outline suggested by me for officering the corps would meet the demands of the Indian Army, but am unable to give any opinion as to whether it would meet with the approval of the War Office.

3. I think my suggestions would attract a good stamp of European recruit, provided that the foreign allowances and pensions were calculated with regard to the requirements of the case, and would also meet the demands of professional opinion in England, as it would do away with the present dual system which is the cause of so much discontent in the Indian Medical Service; and would provide a career for both Indians and Europeans.

4. The result of withdrawing European medical officers from charge of troops, civil districts and jails has been a temporary all round loss of efficiency.

5. The scheme I have outlined for officering the service would I consider meet the needs of the civil government. See answer to no. 6.

6. It would all depend on the strength of the civil appointments held by the corps—but I would supple-

26 February 1919.]

Lieutenant-Colonel J. M. CRAWFORD.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

ment any strength by the following measures so as to increase the military reserve :—

- (a) Officer the Cantonment Magistrates' Department with Indian Medical Service officers—I think the combination of magisterial and sanitary authority in cantonments, in peace time, would increase the efficiency of cantonment sanitation and this would provide an extra reserve of officers in time of war.
- (b) Government civil assistant surgeons, sub-assistant surgeons and compounders should all be made liable to military service during the first 12 years of their service.

7. Indian Medical Service officers in civil employment would revert to military duty at stated times (see answer to no. 5 question to be asked of Service Officers).

Civil subordinates could undergo short courses of military training at the nearest Brigade or Divisional headquarters.

I think it necessary that any reserve should be always actually present in India.

8. As far as officers are concerned I think it has proved of the greatest value. In the case of the Indian General Hospital, I took to England in 1914 all the permanent Indian Medical Service officers in it withdrawn from civil employ, and I believe many medical units in the various theatres of war were officered in the same way.

9. *Recruitment.*—By simultaneous examinations in India and England, through the junior ranks of the Royal Army Medical Corps.

- (a) *For Europeans.*—In England as at present for Indian Medical Service followed by the same courses as the Royal Army Medical Corps go through on joining.
- (b) *For Indians.*—In India, competitive examination among nominated candidates, followed by a course in England the same as for Europeans, also a further course in England on certain medical subjects such as midwifery, gynaecology and hygiene.
- (c) A certain proportion of vacancies to be reserved for Royal Army Medical Corps officers, nominated by Director General, Medical Services.

10. I think special study leave very necessary and that certain courses of study might be prescribed.

But it is useless making rules about study leave unless the cadre of the service is expanded sufficiently to allow all officers to avail themselves of the opportunity offered. At present I consider the cadre of the Indian Medical Service is not sufficiently large to permit officers doing so.

11. A special research department is very necessary.

12. In most stations private practice has long ere this reached the vanishing point—there is no private practice left except in a few of the larger stations and even in them it has much declined.

The reasons for these are the growth of the independent medical profession in India and the increased improvement in communications.

Questions to be asked of service officers.

1. I completed 28 years' service on 30th January 1919. During that time I have actually done 5 years and 15 days military duty.

During my service I have taken part in 4 campaigns :—

One while on military duty—
Lushai, 1892-93.

Three on temporary reversion from the civil to the military department—

N.-W. Frontier, 1897-98.
China, 1900.
War, 1914 to 1916.

My first commission is dated 31st January 1891.

I went to officiate in civil on 13th June 1893.

I was confirmed in civil on 5th May 1895.

I consider it a substantial cause of complaint that the Government have as yet taken no action on the recommendations of the Public Services Commission, and other recommendations that have been made for improving the pay and prospects of Indian Medical Service officers.

Under present conditions the pay and pensions of the Indian Medical Service are quite inadequate, as compared with the emoluments of the medical profession in Britain.

This is proved by the fact that of late years very few Europeans have cared to compete for the Indian Medical Service examination.

When I went up for the examination there were 60 candidates for 12 places, a commission in the Indian Medical Service was then considered one of the prizes of the medical profession, and the candidates competing were generally speaking considerably above the average of the newly qualified medical men.

3. I do not know of any specific instances of friction between the Royal Army Medical Corps and the Indian Medical Service but I am aware there have been such instances and there is a general feeling of discontent at present at the way Indian Medical Service officers have been superseded by Royal Army Medical Corps officers.

4. The formation of a unified corps, department or service.

5. I would suggest the following :—

English for transfer to civil after 5 years' service.

He would, while serving in civil employment, revert temporarily for military duty of training for 6 months before promotion to the rank of major and again for 6 months before promotion to the rank of lieutenant-colonel.

On attaining 23 years' service he would have to elect to revert to military for good, or remain on in civil for good.

Special questions.

1. I think most of the European members of the public services object to being attended themselves, or having their families attended by Indian doctors. More especially in the case of attendance of their wives, I think the feeling is universal.

It is a well known fact that the training of medical men, educated in India, in some branches of the profession, more especially midwifery and gynaecology, cannot compare with the training of men educated in Europe.

In the whole course of my experience in India (28 years) I do not recollect hearing of any case of a European member of the superior services who has had his wife attended in her confinement by an Indian doctor. Even members of the European subordinate services prefer to have only a midwife and dispense with the services of a doctor altogether, if they cannot have a European doctor.

2. Most emphatically No.

I believe they have met the difficulty, generally at great personal expense, which they can ill afford.

(a) By getting transferred to a station where there is a European doctor.

(b) By going to another station to consult a European doctor, or getting a European doctor to come to their stations.

(c) By sending their families to reside in a station where there is a European doctor.

(d) By employing a midwife only for confinements.

I do not think Government have ever considered the amount of worry and anxiety that a young married man, with a delicate wife, and perhaps one or two small children, undergoes when he is sent to a station where there is no European doctor.

I consider Government ought to provide European medical attendance for their European servants and their families, and that they have no more right to force an Indian doctor on a European family than they would have to force a European doctor on an Indian family.

3. I consider the efficiency of Indian Medical Service officers of all grades has increased considerably since I joined the service.

26 February 1919.]

Lieutenant-Colonel J. M. CRAWFORD.

[Continued.]

*(The schemes and questions referred to by witnesses are contained in Volume III.)**Medical Stores Department.*

1. Drugs and instruments for local fund and State aided hospitals and dispensaries in the United Provinces are obtained in peace time by annual Indent on commercial firms of wholesale druggists in India or in the United Kingdom, and by emergent indents on firms in India or by local purchase.

In war time they have been obtained from commercial firms of druggists in India.

2. The civil surgeon is responsible for indenting.

I do not think it would be any convenience if the Government Medical Stores were made the sole source of supply. I personally find it much more convenient to indent on commercial firms.

The objection to an arrangement for supplying such institutions from the Government Medical Store, is the objection of Government interfering with private enterprise.

I consider that for the benefit of the public, it is essential that everything possible should be done to encourage private enterprise in the supply of good and standardised drugs for use of the public in India.

3. No.

Questions to be asked of officers, regarding assistant surgeons and sub-assistant surgeons.

1. I know that sub-assistant surgeons have freely broken their contract and preferred to pay the forfeit sooner than go on military service.

I recommend all sub-assistant surgeons be made subject to the Army Act, during their first 12 years of service.

In this connection I think it would be wise to greatly increase the establishment of military sub-assistant surgeons and second a lot of them for civil duty.

2.

3. By an increase of pay.

4.

5. Yes, or make them subject to the Army Act during their first 12 years of service.

6. I consider the assistant surgeons in headquarters hospitals are over worked during hospital hours. It is

impossible for them to give sufficient attention to all the patients applying for relief. I would remedy this state of affairs by posting a sub-assistant surgeon to each headquarters hospital, as a whole-time house surgeon. I consider this a very necessary measure, and it would increase the war reserve.

7. His proper position is that of house surgeon; how far he can be employed for work outside the hospital such as inspection of lines, troops, etc., will depend on how much work he is given to do in the hospital. The hospital should be his first care.

8. I recommend a period of military training, on the same lines as Indian officers get who are given direct commissions in Indian regiments as jamadars, but on a modified scale.

9.

10. Both might do 4 months' duty in a military hospital during their first year's service.

11. I consider military sub-assistant surgeons should be given rank as jamadars from the day they join the service.

12. I would abolish military assistant surgeons, and replace them by quartermasters and dispensers, posting sub-assistant surgeons, as resident medical officers in British station hospitals.

This, with a commissioned medical officer of the day, should be sufficient. It would lead to some increase in the cadre of officers, but this would mean increased efficiency and a bigger reserve for war.

13.

14. I should make up to the Anglo-Indians for abolishing military assistant surgeons, by providing a number of State scholarships for them at Indian medical schools, and throwing open to them the civil assistant surgeonships and many of the railway medical appointments. I would also raise some European or Anglo-Indian companies of the Army Hospital Corps from which dispensers and quartermasters would be promoted.

15. Yes.

16. No, see answer to 14.

17.

18.

LIEUTENANT-COLONEL J. M. CRAWFORD, called and examined.

(President.) He was in favour of a unified Indian Army Medical Corps. He thought that such a Corps would satisfy the demands of both the civil and military Governments. He did not think that a separate civil service formed partly from the military reserve and partly from a separate civil service would work very well.

He would favour officering the Cantonment Magistrates' Department with Indian Medical Service officers as he thought the combination of magisterial and sanitary authority in cantonments, in peace time would increase the efficiency of cantonment sanitation and this would provide an extra reserve of officers in time of war.

He would recruit for a unified service by simultaneous examinations held in India and in England, and he would reserve a certain proportion of vacancies for Royal Army Medical Corps officers. He thought that this would make the service popular.

He had not personally heard of any instances in which a European civil officer had employed the services of an Indian doctor to attend on his wife during her confinement. European officers of the subordinate services prefer to have a midwife and dispense with the services of a doctor unless they were able to get a European medical man.

A better class of Indian would be obtained if simultaneous examinations were held. He advocated competitive examinations in India for nominated Indian candidates, whom he would send to England for a course of study, the same as for Europeans; also for a further course in special subjects such as midwifery, gynaecology and hygiene.

He favoured the idea of Government granting an allowance to European civil officers to enable them to send

their families to reside in a station where there was a European doctor.

He had been a long time in Benares and his private practice was half what it was before the war. This was due to several private practitioners taking the place of assistant surgeons who had been ordered on active service. The professional efficiency of medical practitioners had greatly increased during the war.

(General Hendley.) He would give two years' training in England at the expense of the State. Indians undergoing training in England would be given a foreign service allowance to compensate them for being away from their native land. Indian officers employed in India would get the same rates of pay as a British officer gets for performing similar duties in England. He would also give European officers serving in India suitable foreign service allowance.

It would interfere with the civil administration if officers were sent for military training at more frequent intervals than had been suggested.

On attaining 23 years' service an officer should elect to revert to military for good, or remain in civil for good. He saw no objection to limiting the period to 20 years but he thought this was rather short.

With regard to the establishment of district hospitals he would put them under the charge of the civil surgeon, and he would charge a small fee for all non-entitled persons.

(General Giffard.) Discontent in the Indian Medical Service was due to the wholesale way in which Indian Medical Service officers had been superseded by Royal Army Medical Corps officers. In the event of a unified service being formed he would remedy matters by making Royal Army Medical Corps officers give up their seniority. This would cause a hiatus and he would second a certain number of Royal Army Medical

26 February 1919.]

Lieutenant-Colonel J. M. CRAWFORD.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

Corps men to fill up the gap. It would not be possible to equalise matters if a unified service was not formed.

He would admit 30 per cent. of Indians to the new corps.

With regard to the question of simultaneous examinations he thought that the best way of dealing with this would be to have separate examinations. His object was to get the best men in England and in India.

He considered study leave very necessary and that certain courses of study should be prescribed. He thought it useless to make study leave rules unless the cadre of the service was expanded sufficiently to allow all officers to avail themselves of the opportunity offered. Study leave should be considered as duty.

All civil sub-assistant surgeons should be subject to the Army Act during the first 12 years of their service.

(General Hahir.) He did not anticipate any difficulty in getting sub-assistant surgeons to enter the service even if they had to undergo a course of compulsory military training.

He said that Indian Medical Service officers on the reserve had been most useful. He quoted his own case by saying that he had been reverted to military duty from civil on three occasions.

With regard to his suggestion that Indians should be nominated before competing for the entrance examination, the provinces should nominate candidates in the same way as they now do for King's commissions in the Indian army.

The work on the civil side had increased enormously; civil hospitals were at present undermanned. He could do with another assistant surgeon in his hospital.

He would abolish the military assistant surgeons as there was no place for them. He would replace them by quartermasters and dispensers. He would make up to the military assistant surgeons by throwing open to them the civil assistant surgeonships and many of the railway medical appointments.

He did not think the creation of an Advisory Board was necessary.

DR. R. K. TANDON, Lucknow.

*Written statement.**Suggestions for the reorganization of the medical services in India.*

The question of the reorganization of the medical services in India is one that requires a long and patient study before any practicable and feasible scheme safeguarding the interests of both Europeans and Indians can be suggested. And yet we have been asked by the Government to give our opinion in the space of a comparatively short time. I, therefore, submit that the scheme presented below is only a skeleton of what one could have done if there had been sufficient time allowed to draw it up. The following scheme is presented in the form of answers to the questions which were sent to me by the Government:—

Q. 1.—What defects have you noticed in the organization of the Royal Army Medical Corps and the Indian Medical Services in India? Does any one of the attached schemes, which are suggested with a view to remedying existing defects, commend itself to you, and if so, which and why?

A.—The chief defect that the world-war brought out prominently to the notice of every one was the fact of the inadequacy of the war reserve in the organization of the medical services in India. It was distinctly shown that external help had to be obtained before the conditions produced by the huge war could be met. In my opinion the war reserve should at all times be adequate so that outside help may not have to be taken in times of emergency. Another defect is the practically permanent nature of the civil appointments held by the members of the Indian Medical Service, which impairs their efficiency for military duties and makes a good proportion unfit for military work.

None of the schemes sent by the Government can be acceptable to an Indian, as an essential feature in each one of them is to foster and develop practically a purely European combined medical service for the benefit of the military medical officers. The schemes do not take into consideration, or I should say the framers of the schemes under discussion, do not take into consideration the legitimate aspirations of the Indians and do not aim at creating a progressive senior civil medical service, which in the near future may be manned by Indians mainly—an aspiration to which they are entitled by virtue of their birth-right as well as the fact that His Majesty's Government have given a pledge to this effect in their announcement of the 20th August 1917, and which fact has further been ratified in the Report on Indian Constitutional Reforms (Chelmsford-Montagu Reforms).

To meet these requirements I beg to suggest the following scheme:—

1. The present civil and military departments should remain as two separate organizations with two distinct medical heads.

2. The military medical service should consist of the present Indian Medical Service, Royal Army Medical Corps, the military sub-assistant surgeons and the Indian Hospital Corps.

The present military assistant surgeon grade should be abolished and absorbed into that of the civil assistant surgeons, since now the former would have to undergo a full five years' course of instruction and would thus begin to possess a registrable qualification recognised by the General Medical Council of England. This would remove the unnecessary irritation and jealousy which at present exists among the members of these two classes of medical officers.

The strength of the military medical service should be fixed according to the strength of the army in India.

3. The civil medical service should consist of—

(a) Senior grade which should be recruited as follows:—

(i) Military officers deputed to the civil side from the medical services.

(ii) Medical officers recruited by a competitive examination held simultaneously in England and India.

(iii) Officers recruited from the provincial medical service by selection and promotion. I would here suggest that after selection these officers might undergo a post-graduate course of instruction at some recognised college in India. But it would be to the advantage of these men if they could be granted study leave and certain allowances to proceed to England in order to receive post-graduate instruction which would eminently qualify them for the work they would be called upon to do in the senior grade of the civil Indian medical service. I would also beg to suggest that selection for the senior grade of the civil Indian medical service should not be made from among civil assistant surgeons who are senior in service but from among those who are young and junior. A civil assistant surgeon, if otherwise qualified, may be promoted to this grade after ten years' service. In the matter of selection for the senior grade educational qualifications should be the chief consideration. An assistant surgeon possessing higher qualifications than his fellows should have preference over the others. And for this purpose men holding British qualifications should have the preference.

26 February 1919.]

Dr. R. K. TANDON.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

A start in this direction may be made by retaining 50 per cent. of the present total civil appointments in the hands of the members of the military services, 40 per cent. in the hands of the members of the provincial medical service and 10 per cent. may be given to those who pass the simultaneous examination held in England and India. In subsequent years all vacancies shall be filled by simultaneous examination till the following proportion is reached:—

- (i) Military men deputed to the civil Indian medical service—25 per cent.
- (ii) Recruitment both in England and in India by simultaneous examination held in both the countries—50 per cent. Half of the number to be recruited in England and the other half in India.
- (iii) By promotion and selection from among the civil assistant surgeons—25 per cent.

In all cases the standard of medical qualification now required for the Indian Medical Service should be insisted upon. In case of senior grade medical officers recruited by examination in India, it should be made compulsory that after appointment they shall have to undergo a further post-graduate course for two years in England including the period for military training.

- (b) Junior grade civil Indian medical service consisting of:—

- (i) Civil assistant surgeons, and
- (ii) Sub-assistant surgeons.

Recruitment for these officers should be as at present.

All members of the senior grade civil Indian medical service should be made liable to do military service during an emergency like the last world-war, and on joining service should undergo a military training. This military training may be given them after every five years until they have attained the age of 40 years after which they should be exempted from it. This rule should also apply in the case of those civil assistant surgeons who have been promoted to the senior grade of the civil Indian medical service.

The civil Indian medical service shall be under the provincial governments. The period of probation for members of the senior grade civil Indian medical service promoted from the junior grade should be two years on joining appointment. The same period of probation should be observed in case of those officers who have been lent to the civil side from the military service. The provincial governments shall have full power to revert such officers to military department at any time during their probationary period.

All civil medical appointments shall eventually be held by the members of civil Indian medical service, such as the Jail, Sanitary, Bacteriological, etc., except those appointments which are "indispensable" even in time of war. These should be held by either senior members of the civil Indian medical service who are not likely to be reverted to the military department during the war, those military medical officers who have permanently been appointed to the civil side for some reason and the independent medical practitioners possessing necessary qualifications. The "indispensable" appointments shall include higher administrative and educational posts. While on the subject of educational posts, I might suggest that these appointments should not be reserved for the members of the civil Indian medical service only far less for those who belong to the military medical service. These appointments should be open to every one. Men to fill them should be advertised for and applications called for from all properly qualified men both in service and out of it. Selections should then be made by an Advisory Board consisting of the administrative officer with the provincial government, a member of the University in the Faculty of Medicine, and an independent practitioner. The appointment to a professorial chair should not be confined to the province, but applications should be called for from the whole of the country as well as from the United Kingdom. After the Advisory Board has made its selection it should report to the provincial government with whom shall rest the final selection.

The military medical officers should be lent to the civil side for a limited number of years only. I think that a period of five years should suffice. This will enable a larger number of such officers to have an experience of the civil work than they can get at present and would remove the sore cause of jealousy which exists at present among the members of the military services. While doing service on the civil side these officers should get their pay and pension, etc., on the same scale which they would have got if they had stayed on the military side.

Q. 2.—Do you consider that the scheme which you commend will meet with the approval of the War Office, and that it will meet the needs of the army in India? Have you any criticism to make in either connection.

A.—Any scheme which provides an adequate reserve for the medical service in time of war as well as satisfies the needs of the army in India should meet with the approval of the War Office. According to the scheme suggested by me the war reserve has adequately been provided for, as it would be amply supplied by the members of the present Indian Medical Service and Royal Army Medical Corps. These would form the ordinary reserve, and their number should be supplemented in war time by men from the civil Indian medical service, I mean from both the senior and junior grades of the civil Indian medical service. These men when detailed for military service during war should be given commissioned military rank according to their seniority in service.

The independent medical practitioners should form a civil reserve in war time and will take the place of senior and junior grade civil Indian medical officers withdrawn for military duties.

Every member of the civil Indian medical service, if it is thought necessary, and that up to the age of 40, should undergo a periodic military training, after every five years or longer and should be liable for military duty in times of emergency. I am of opinion that before their appointment the assistant surgeons should be made to sign a bond to the effect that they shall be liable in their own grade and on promotion to the senior grade to serve in the army should occasion require up to the age of 40, and they might be given military training for a year or so to qualify them for work in the army later on.

It will thus be seen that it would be possible to provide a sufficient war reserve for any emergency and at the same time create an independent civil Indian medical service. It should also satisfy the needs of the army and meet with the approval of the War Office. This suggestion if carried out would also prove economical in the long run. I am sure that in this connection "considerations of efficiency and economy as well as of military necessity and the satisfaction of the just claims of the people of India, have all to be borne in mind and reconciled to any solution of the problem that will last."

Q. 3.—Do you consider that the scheme which you prefer will attract a good stamp of recruits and meet the demands of professional opinion in England and in India? If the scheme which you prefer fails in either respects how would you remedy such failure?

A.—The scheme proposed by me may affect the Indian Medical Service as it is at present situated. To meet this difficulty, the Army Medical Services should be a unified service composed of both Indian Medical Service and Royal Army Medical Corps making the conditions of the two services equal as regards pay, pension, etc., and making their duties in the military identical. There should then be no reason why both the services should not draw capable men from England.

The civil Indian medical service should be attractive and remain so, by its being well paid, chances it would offer of promotion to higher administrative grade as well as to specialised posts, and last but not least, by its allowing means of augmenting one's income by private practice. The rule for study leave and other kinds of leaves should be so framed as would give chances to the members of the service to keep themselves up-to-date and allow facilities to them to get periods for stay in England to recuperate their health.

26 February 1919.]

Dr. R. K. TANDON.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

Q. 4.—What has been the result of withdrawing European medical officers from charge of troops, civil districts and jails in India?

A.—I cannot say if there was falling off of the efficiency in the work in the army by the withdrawal of European medical officers. The army officers would be the best persons to answer this question. But as regards the administration of jail and the civil departments, as far as I know, there was no falling off of the efficiency in the work done by those who replaced the European medical officers in the civil department. The following figures given below for the United Provinces of Agra and Oudh of the work done by the hospitals during the past few years would substantiate my remarks. It will show at a glance that handing over of the charge of the district duties to the Indians has in no way produced unpopularity or deterioration in the work of the civil districts:—

Year.	Operations.	In-patients.	Out-patients.
1908	191,180	69,053	4,600,088
1909	188,045	69,741	4,866,858
1910	196,526	69,536	4,474,100
1911	199,794	65,954	4,234,550
1912	204,756	70,194	4,245,694
1913	212,801	75,826	4,318,651
1914	217,014	75,426	4,432,919
1915	235,822	77,277	4,979,254
1916	236,812	80,228	5,158,398
1917	228,775	81,369	5,270,954

The Inspector-General of Civil Hospitals, United Provinces of Agra and Oudh, in his speech at one of the meetings of the local Legislative Council gave his testimony to this effect. It is quite possible that during the first year of the war there might have been some fall in the efficiency of the jail and district hospital work. This can be accounted for by the fact that the officers had to assume charge of the administrative duties suddenly, duties to which they were new and the subordinates with whom they were thus suddenly brought into contact were not amenable to control and discipline as they would have been under an experienced officer of the department. After all the fall if any, was inconsiderable and quite inappreciable. I am told that in later years there was a distinct tendency towards improvement as the officers gained experience of their work. This is only natural and cannot be taken as an argument against the Indians who had to officiate for the Indian Medical Service officers. On the other hand it should go in their favour that without experience they did so well in the sphere which was quite new to them.

Q. 5.—Will the scheme you recommend meet the needs of the civil administration in India? To what extent would it be affected by needs occasioned by war on a large scale?

A.—I think that the scheme recommended by me would in every respect meet the needs of the civil administration. I do not see any reason why it should not, considering the fact that sufficient provision has been made for the war reserve as well as the particular needs of the civil departments. In time of war the members of the civil Indian medical service who are holding the administrative, educational and specialised posts will remain there. Other members will be replaced by men from the assistant surgeon grade and the independent medical practitioners, who will thus form a civil war reserve. The civil, therefore, cannot suffer even in a world-war like the last.

Q. 6.—Would the scheme you recommend give a sufficient and efficient reserve for military purpose? If not, how would you supplement it?

A.—The scheme proposed above will give a sufficient and efficient reserve for military purposes at the shortest possible notice. If further supplementing would be required, men would be available from among the independent medical profession of the country, who should be asked to volunteer in peace time. They should be given a retaining fee and made liable for military duty in war time. It is quite possible that this class of men may be found willing to volunteer even without any retaining fee, provided they are given honorary mili-

tary rank and are, on special occasions, allowed to wear uniform pertaining to their rank. I have also stated above that men of this class could replace the members of the civil medical services which they would do willingly although they may not volunteer for military duty.

Q. 7.—Do you consider that it is necessary to have a medical service reserve for war previously trained in military work, and must such reserve be always actually present in India?

A.—In this scheme there would always remain a considerable number of medical service reserve for war previously trained for military work in India.

Q. 8.—How far has the Indian Medical Service reserve (civil side) proved of value in the war?

A.—I am not in a position to answer this question.

Q. 9.—What system of recruitment and education do you recommend as desirable for medical officers in connection with the scheme which you prefer?

A.—See *ante*.

Q. 10.—Have you any suggestion to make as to the grant of special leave for study or as to prescribing periods of study?

A.—See *ante*.

Q. 11.—Have you any suggestions to make as regards the provision of special department for research?

A.—In my opinion a Central Research Institute should be established in each province and every opportunity given to men in service as well as to the independent practitioners for doing research work if they so desire and the Government should finance such a scheme liberally.

Q. 12.—How far has private practice declined in the case of officers of the Indian Medical Service in civil employ? If it has declined what are the reasons?

A.—I am of opinion that there has been no appreciable decline in the private practice of the Indian Medical Service officers, taken as a whole. I believe that as the western system of treatment is getting appreciated more and more by the people of India and as the specialised posts have been created among the members of the Indian Medical Service the opportunities for private practice among the members of the Indian Medical Service have very much increased. It is being assumed that since the number of the private independent medical practitioners has increased during the last thirty years the practice of the Indian Medical Service officers must have correspondingly decreased. It should be borne in mind that along with the increase in the number of independent practitioners there has also been greater demand by the public for the votaries of the western system of treatment. The assumption, therefore, cannot stand the test of close examination. In smaller districts and towns the civil surgeon could not have enjoyed an extensive practice. In such places practice has always been consultant and surgical and still remains so. This is because the civil surgeon has at his disposal all the latest appliances of a well-equipped Government hospital which the independent practitioner has not, and naturally all the surgical cases go to the civil surgeon. The same remark equally applies to the larger towns where specialist Indian Medical Service officers and the civil surgeon carry on a roaring practice simply because, thanks to the Government and other private donors, the hospitals are well equipped with all up-to-date appliances of all kinds, which the private practitioner cannot afford to have at his command. The surgical and special practice, therefore, remains the monopoly of the Indian Medical Service officers. I am firmly of opinion that a civil surgeon of a big town earns just as much to-day from private practice as he did before. If he cannot earn more it cannot be owing to competition. Surely there should be a limit to the physical capacity of every human being and the civil surgeon comes under this category. As a matter of fact all surgical, bacteriological and a good deal of consulting practice is still in the hands of the Indian Medical Service officers.

26 February 1919.]

Dr. R. K. TANDON.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

Dr. R. K. TANDON, called and examined.

(President.) The witness was educated at the Agra College up to the Intermediate class. He then went to England at the age of 19 and was educated at Edinburgh for five years. On return from there he served for some time in the Bharatpur State and subsequently joined Government service and remained in service from 1895 to 1906. He was State surgeon at Bharatpur, then became an Inspecting officer, was for some time assistant chemical examiner, and was in charge of a hospital when he left the service. He had been a private practitioner since 1906.

There should be a separate civil and military medical service. Half and half of each service should be recruited by competitive examinations held simultaneously in England and in India.

(General Giffard.) The pay, pension, etc., of the Indian Medical Service and Royal Army Medical Corps should be the same. This would remove a great cause of irritation among them. He had suggested a unification of the services so as to avoid any difficulty about the short term pay and the long service pay in India. He did not mean to suggest that the same pay and pension should be given to those who came here only for a short time and to those who spent 30 years here. His intention was that the pay and pension should be proportionate to the time that these officers were in India.

By a purely civil medical service he intended a service in which none but civilians would be recruited by competitive examination. They should be given a periodical military training, as without this it would not be possible to create a war reserve. The only difference between a purely military service in civil employ and a purely civil service in military employ would be that if it were a purely military service its members would be taken away whenever there was even a small war. The civil should, however, serve the purpose of a second reserve and not that of the first reserve. In the first place the military people would be drawn away and then the turn of the civil would come. In the case of a small war no call would be made on the civil.

With regard to the question as to what would be gained by a purely Indian civil medical service he was of opinion that civilians had as much a right to have their own medical men to look after their health as the military. There should be two distinct services, one purely civil and one purely military, which would be a more economical arrangement than the present one. At present all the big posts were the monopoly of the military who formed the war reserve. A civil medical service would be cheaper than a military service.

The equality of standard in the simultaneous examinations held in India and England could easily be secured by prescribing the same papers in both places. The examinations could also be held on the same date, the examination in England being held 7 hours later than in India so as to avoid the telegraphing of papers. If it were held at 10 in the morning in India it could be held at 5 in the evening in England so as to make it simultaneous. To avoid the examinations being held in hot weather the two six monthly examinations could be held in March and October. The clinical cases for the students would no doubt be different but even in England all the students did not get the same cases. The Indians who had proceeded to England should sit up for the examination held there and any European who could not go to England should appear in the examination held in India. It was not his intention that the 50 per cent. recruited in India should be Indians or that the similar percentage sitting for the examination in England should be Europeans. So long as there were simultaneous examinations he did not care even if all the candidates were Europeans. He did not specify any percentage for any nationality except that the colonials should not be admitted. All that he intended was that 50 per cent. should be recruited by

the examination held in India, whether they be Europeans, Anglo-Indians or Indians, and the same applied to the examination held in England where the candidates might be Indians, Europeans or Americans. This system would make it easier for the intelligent Indians who could not afford the expenses of a journey to England to join the medical service as they would have a chance of being examined here. The students recruited in India should be sent to England for training for two years and those recruited in England should have training in tropical diseases for two years in India.

(Mr. Hignell.) The 50 per cent. recruited by examination in India need not necessarily be Indians as there might be some Anglo-Indians and even Europeans among them as some of the latter who could not go to England might appear in the examination in India. He did not anticipate that as a result of this simultaneous examination practically the full 50 per cent. recruited here would be Indians.

He had no experience of the other parts of the country but so far as Lucknow was concerned the number of private practitioners had increased during the last ten years.

Even though the law was overcrowded he did not think that the attractions of the medical department would be greater than in the past to Indian students, as they knew that the medical examinations were much more difficult than the law examinations and more time had to be devoted to study for them, the course at Lucknow being one of 6 years. The reason why Indians preferred the legal to the medical profession was that the examinations in the former were easier and the course was a shorter one. Besides the standard of education in the medical college was stiffer.

In the last ten years there had been an increase in the number of Indian practitioners and there had also been an improvement in their professional qualifications, and this would continue in the future.

(General Hendley.) The men recruited for the senior civil medical service, suggested in his written statement, should be sent to England for training for two years. Government would have to pay for their expenses, as the students would be considered to be in Government service as soon as they passed the examination, their service counting from that very date. Government will thus have to pay all the expenses of sending them to England. On the same principle the students recruited in England would have to receive two years' training in tropical diseases on coming out to India, and they should not be expected to do any professional work during the first two years of their stay in this country.

Military medical officers should be lent to the civil side for a period of five years at a time. They should then revert to the military and other men should come in their place. They might come again to the civil in their turn next time. In this way every military officer would have a chance of working in the civil, and the system would do away with the present state of affairs under which some persons were selected for employment in the civil and remained there and other people who could not get into civil grumbled. This would remove the sore cause of jealousy that existed among the members of the military service. He himself had come across several members of the service who had made such complaints.

(General Hehir.) Colonials should not be permitted to join the medical services. They should be accorded the same treatment as meted out to Indians.

He himself did not compete for the Indian Medical Service as his father did not like him to do so as he was his only son.

It was true that the war reserve did not break down in the previous small wars, but it was better to provide

26 February 1919.]

Dr. R. K. TANDON.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

for a contingency like this war so that the reserve should not fail in emergency.

Schemes B and C practically excluded Indians from joining the superior medical services. Of the four schemes, scheme D was the best and the scheme he had proposed was based on that.

If the scheme he had suggested were accepted there would be no danger of the reserve failing in the case of a big war.

Indian practitioners appreciated the grant of honorary military rank and the privilege of wearing uniform on special occasions.

Rai Bahadur Doctor M. N. OHDEGAR.

Written statement.

1. I have no knowledge of the organisation of the Royal Army Medical Corps and do not therefore feel entitled to offer any opinion on it. The principal defect in the organisation of the Indian Medical Service is that the examination is held only in England and this is a powerful factor in keeping the majority of eligible Indians out of it. In the present organisation of the Indian Medical Service the needs of the civil population have been entirely subordinated to military needs and not infrequently a square man is put into a round hole. Then again if an Indian Medical Service officer in civil employ proves himself unfit to be retained in it, the provincial government has no power to revert him to the military department without the sanction of the Government of India. None of the schemes sent (A, B, C, D) commends itself to me. Educated Indians, for the last 25 years or more, have been asking for a civil medical service quite distinct from the military service; all the four schemes tend to strengthen the position of the military on the civil side rather than lessen it.

I have drawn up a concise scheme for the re-organisation of the medical services in India and beg to submit it to the members of the Committee for their consideration. (Scheme attached.)

2. I am unable to say if the scheme which I am submitting will meet with the approval of the War Office; but I venture to think that it will meet the needs of the army in India and will certainly give satisfaction to the public at large in the country.

3. There is no reason why the scheme I am suggesting should not attract a good stamp of recruits. In the event of the scheme not attracting a good stamp of European recruits, the country should try on the civil side to do without them for a few years to help the sons of the soil to come into their own, rather than depend for ever on a supply from the British Isles. I see no reason why Britishers (*Colonials excluded*), of good stamp, should not be attracted to the military medical service. Practically all the four schemes say that the "Medical degrees and qualifications gained in India, do not, in all cases, represent the result of a complete medical education."

If this statement be correct, does it not form a strong commentary on the capabilities of the Indian Medical Service officers by whom the colleges in India are manned? It is for the Government to enquire and find out why a "complete medical education" cannot be had in India—especially when we are told that in the cadre of the Indian Medical Service there are ever so many "specialists." Surely the fault cannot lie with the brain and intelligence of the Indian students.

4. I regret I am unable to state from personal experience the result of withdrawing European medical officers from the charge of troops; but venture to think that the districts and jails in India did not suffer in any way. I have not heard that there have been more than normal escapes, if any at all, from the jails, nor have I heard that the administration generally suffered in any way. If there has been any slight deterioration in the administration of the jails, it was, more likely than not, due to the fact that the jail staff were not amenable to the control of the superintendents for the reason that these latter were only temporary hands. The districts could not have suffered in professional matters; but I should not be surprised if some of the officials have complained in this matter—the complaints being due to obvious reasons. I have heard of complaints in a very few instances in respect of medico-

legal work, but we must recognise that owing to peculiar circumstances due to war every Ram Din and Maula Bux who was available had to be taken on. The falling off in efficiency in this line was chiefly due to want of experience.

5. The scheme I recommend should meet the needs of the civil administration in India. Should war on a large scale break out, the younger officers of the civil department can be transferred to the military for such time as their services might be wanted; and if need be private practitioners might be asked to volunteer their services as was done between 1914 and 1916.

6. My scheme provides for a sufficient and efficient reserve for military purposes.

7. I consider it very necessary to have a medical service reserve for war previously trained in military work, and my scheme provides for it. A certain proportion being thus provided for, and there being a certain number of Indian Medical Service officers also available, the rest of the reserve need not be always actually present in India.

8. The Indian Medical Service reserve, civil side, I believe, proved of great value in the war which is just over, though the medical arrangements in Mesopotamia proved to be a fiasco, possibly not through the entire fault of the Indian Medical Service officers concerned. The Indian Medical Service reserve proved insufficient to cope with the work and over 700 non-Indian Medical Service medical men had to be requisitioned for work in the military department.

9. I should recommend that for the present an open competitive examination be held simultaneously in England and India for recruits, for the Indian civil side; that only men holding qualifications registrable in England be allowed to compete; and that the top-most men be taken into service irrespective of caste, colour or creed; but I would under no circumstances allow a colonial to compete for service in India. The men selected in India should be compelled to go to England for at least one year, at Government expense, for military training and for specialising in certain subjects. These young men should be encouraged to take high British degrees if they wish to do so. The men engaged in England should also undergo military training and pass an examination in Urdu or Hindi before coming out to join their appointment in the civil department.

10. Special leave, in my opinion, should be granted for a period of six months or more every five years to enable the civil medical officers to go to England, America or any other European country for post-graduate study.

11. In my opinion there should be a central research institution in India open to all qualified medical men. Any private practitioner who wants to take up research work should be admitted as freely as men in the service.

12. Taken as a whole, I do not think that the income from private practice has declined in the case of officers of the Indian Medical Service in civil employ. If I carry my memory back to forty years ago and compare the conditions that then existed with those of the present, I am decidedly of opinion that the income of the Indian Medical Service officers, as a whole, is much more than it was then. In olden days only a few of them had any appreciable income, but there were a very few who, I

26 February 1919.]

Dr. M. N. OHDEGAR.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

must admit, got big fees on certain occasions. There are hardly any big fishes to be netted now, but the smaller fishes if collected together, would weigh much more than the few big ones. The few capable men who know how to get on with the people of the country, make a steady big income such as their predecessors some years back could not dream of.

If the income of any particular officer has declined it cannot be due to any want of appreciation by the public of the European system of treatment. The causes should be looked for somewhere else. In my opinion it is a mistake to think that the income of the Indian Medical Service officers has gone down on causes should be looked for somewhere else. In tions. It is probably the other way about. There has, however, been a steady diminution of late in the perquisites of the Indian Medical Service officers.

NOTE.

Of the four schemes sent to me, scheme A is hardly worth any consideration as it proposes to benefit Royal Army Medical Corps chiefly and is calculated to bar military service to Indians and deprives them of the right which they now have of entering the commissioned ranks of the Indian Medical Services. Reading between the lines it also appears to me that under this scheme almost all the higher appointments in civil employ would go to officers of the Royal Army Medical Corps.

Scheme B is also not worth consideration since it makes no provision for the recruitment of Indians in India, and is also apparently not prepared to give them a reasonable share of the higher civil and military appointments. This scheme therefore goes directly against the legitimate aspirations of the people of the country. These defects are also to be found in schemes C and D.

Medical Stores Department.

1. Till about the end of last century stocks of drugs and instruments of local and civil dispensaries and civil hospitals were obtained from the Government Medical Stores Depots by means of indents prepared by the medical officers in charge of the institutions and checked by the Inspector-General of civil hospitals. I believe the same procedure still holds good as regards the civil hospitals and dispensaries supported wholly by Government. About twenty years ago district board hospitals and dispensaries were allowed to obtain their supplies from certain firms approved by the Inspector-General of hospitals and I believe the same procedure holds even now.

2. As stated above the indents are prepared by the civil assistant surgeons in charge of sadar dispensaries. I do not think that there would be any advantage in making the Government Medical Store Depots the sole source of supply. If the hospitals are allowed, as they now are, to obtain their supplies in the open market the chances are that the prices will be kept down. Besides, it is impossible at this time of the day to compel local bodies to obtain their supplies from Government Depots. I quite agree with the recommendations of the Industrial Commission regarding the encouragement of private enterprise for the local production and manufacture of drugs and stores. To obtain an equal standard in quality, reduction in cost, increased manufacture in India and economy in freight, etc., Government should encourage such enterprise by granting concessions with regard to raw materials available in Government property, e.g., the State forest, and also where possible facilitate the collection of raw materials by means of favourable railway rates. Government should also help such enterprise with grants or subsidies by guaranteeing a minimum return or by undertaking to make purchases.

3. If I remember right, the working of the Medical Store Depots, when the district hospitals used to get their supplies from them, was not very satisfactory.

On many an occasion the Depots were unable to supply all the drugs indented for and not infrequently the supplies were received piecemeal.

A scheme for the regulation of the medical services in India.

1. The Indian Medical Service, when first regularly constituted, was primarily a military service charged with the care of the sick of the Indian army. One of its subsidiary duties was to attend Europeans employed in the civil departments of the State; and another important collateral duty was to spread the western medical science amongst the people of the country. In furtherance of these objects, some members of the Indian Medical Service were posted under the civil government, forming a war reserve. The members of this service, as a whole, have done their work exceedingly well. Special credit is due to them for the ability with which they have conducted the medical colleges in the country, where all the professorial chairs have till recently been always held by them. The officers of the Indian Medical Service, who are military officers, had to be drafted into the civil department at a time when qualified men of the country were either not available or available in very small numbers. Conditions are, however, changing and the sooner Government takes notice of it the better for everybody concerned. Now there is a very large number of men of the country who have so well profited by the training imparted by these professors that they are in no way inferior to the average general practitioners in any country, while some will compare favourably with the best general practitioners anywhere. Instances are also not wanting where Indians have qualified themselves as specialists in certain departments of work. Apart from these, there are now many Indian practitioners who hold very high British qualifications.

2. The wishes expressed by the Secretary of State for India in his despatch no. 137 (Military), dated 9th August, 1907, as also the suggestions of Lord George Hamilton for appointments of independent practitioners either to new appointments or to some of the posts which are regarded as a reserve for the members of the Indian Medical Service remained as pious hopes and came to nothing. The misfortune is that the medical department under the Government of India is the only department in which the interests of the officers clash with those of their assistants and of the alumni of the medical colleges in this country; and it is owing to this stumbling block that the claims of the Indian medical men for responsible posts have not yet been freely recognised. A time there was when all the important medical appointments could not but go to the members of the Indian Medical Service, but now with the large number of qualified men turned out by the medical colleges in this country and the number of men possessing British and American qualifications, there is hardly any reason why a good number of the higher appointments should not be given to the people of the country. The recognition of the claims of the medical men in this country will not only make them contented but result in the saving of a large sum of money which could be diverted towards further spreading medical education or in improving the existing medical colleges and schools.

3. I recognise that the very high appointments in the medical department should still, for some years to come, be reserved for the officers of the Indian Medical Service, be they European or Indian; but a great number of civil surgeoncies and a good number of appointments in the Sanitary Department might now well be given to qualified natural-born Indian subjects of His Majesty with advantage to the country and the finances of the Government of India.

4. Subjoined is a scheme which I respectfully submit for the consideration of the Medical Services Committee.

26 February 1919.]

Dr. M. N. OHDEGAR.

[Continued.]

*(The schemes and questions referred to by witnesses are contained in Volume III.)**All-India Scheme.*

5. The following appointments should be reserved for the officers of the Indian Medical Service or of the proposed unified Royal Army Medical Corps :—

- (a) Director General of the Indian Civil Medical Service.
- (b) Surgeons-General and Inspectors-General of Civil Hospitals in the different Presidencies and Provinces.
- (c) Residency surgeons.
- (d) Agency surgeons.
- (e) Presidency general hospital surgeons.
- (f) Inspectors-General of Jails.
- (g) Sanitary Commissioners of Provinces.
- (h) Superintendents of Central Jails.
- (i) Sanitary Commissioner with the Government of India.
- (j) Principals of medical colleges.
- (k) Civil surgeons of headquarters of divisions.
- (l) Civil surgeons of hill stations.
- (m) Civil surgeons of Port Blair and Andaman Islands.
- (n) Civil surgeons of some important stations as Cawnpore.

6. After providing for the Indian Medical Service officers, whether Indian or British, in the civil department in the way stated above, it appears to me that the time has come when the civil surgeoncies of the rest of the districts should be thrown open to Indians and the other subjects of His Majesty the King-Emperor, except colonials, and at least one half of the professorial appointments in the medical colleges reserved for them. It is also desirable that some of the other appointments be given to non-Indian Medical Service men; for instance the chemical examinations. There seems no reason why an assistant chemical examiner, who has worked for years with credit and has earned distinction in the scientific world, should not be promoted to the post of chemical examiner. It is often said that Indian medical men do not specialize; but what encouragement and facilities are given to them? With such instances before them, in which the claims of really efficient men have been ignored, the young men in this country who are given no facilities in the shape of study leave, etc., cannot be expected to take up any special subject and become experts in any special branch of the medical science.

7. The civil medical service in India should be divided into two classes—senior and junior. The latter should consist of those medical officers who would be employed in district board hospitals and dispensaries under the new self-government scheme. The method of recruitment for senior class should, in my opinion, be as follows :—

Twenty per cent. of the appointments in this grade should be filled up by promotion from the class of medical officers now termed civil assistant surgeons. This process should continue during the transition period, i.e., until the whole of the present incumbents get removed either by promotion, retirement, or otherwise. Only capable young men of, say, 10 to 15 years' service should be eligible for promotion. In this list will also be such Indian Medical Service officers as are mentioned in para. 5 above. These officers should be permanently on the civil list and not liable to transfer to the military side except in the event of a big war. They should retain their military ranks and I see no reason why the Inspectors-General should not get the rank of "Colonel." These two classes of officers being provided for, the rest of the appointments should be thrown open to young men holding British and Indian degrees by means of a competitive examination held simultaneously in England and India. Before taking up their appointments they would have to go through a course in military

medical subjects in England and the Britishers have to pass an examination in Urdu or Hindi by the lower standard. All the candidates on arrival in India might be attached to a station hospital for six months. My idea is that there should be only one cadre throughout India for the senior medical officers and that the members of this cadre be called civil or district surgeons and resident surgeons according as they are in charge of districts or in charge of district hospitals. I recommend that the district hospitals throughout India be Government institutions without any connection with the district boards. The required number of candidates having been selected by an open competitive examination should be placed in charge of these district hospitals under the designation of resident surgeons. After ten years' service these officers should be promoted to the rank of civil or district surgeons. Any one having exceptional merits should on the recommendation of the Inspector-General of hospitals be promoted to the rank of district surgeon after five years' service as resident surgeon. There is no reason why medical men of the British Isles should not begin life in this way. If this method were adopted, in the course of time, this cadre would consist only of men who either belong to the Indian Medical Service or have come in through the competitive examination recommended. I would not take any recruit into this senior service direct from the medical colleges.

8. An objection might be raised to this one-cadre scheme on the ground that in the course of time a large number of districts would be under the medical charge of Indians and that it would not suit the British officials of those districts. I am quite aware of the fact that it is often urged that the European officers object to have their families attended by Indians. There might be, and I daresay there is, some truth in it, and we cannot ignore sentiment; but instances are not wanting where European officers not only do not make any objection but are only too glad to accept the services of Indian medical officers for their families. I am a great admirer of the British nation and I know that amongst other good qualities they possess one that enables them to adapt themselves to their surroundings. Prejudices are hard to die, but there is no doubt that this prejudice of the Britishers is steadily, though slowly, dying out.

9. *Pay.*—The pay of the recruits admitted after open competitive examination and that of the assistant surgeons now in service selected for promotion to the all-India cadre, should be from Rs. 450 to Rs. 600 per month, as long as they are resident surgeons. They should have the privilege of engaging in private practice. When an officer becomes a district surgeon his pay should be Rs. 800 rising to Rs. 1,200 per month by an annual increment of Rs. 50. The Indian Medical Service officers on this cadre should get the pay of their rank *plus* such allowances as might be admissible under the existing rules of their service. The Indian Medical Service officers might, if necessary, be given an extra allowance of 12½ per cent. on their consolidated pay.

10. *Military assistant surgeons.*—The majority of the military assistant surgeons do not hold a qualification registrable in Great Britain, but some do; and the rights and privileges of these latter should be safeguarded. These few men should be absorbed in the senior grade, recommended men on the same pay as the others. If the retention of the Indian Medical Department officers in the civil department be required as war reserve, we must not shut our eyes to the requirements of the Government. These officers might easily be employed on the civil side under :—

- (a) Jailers of central jails.
- (b) Medical officers of State railways.

26 February 1919.]

Dr. M. N. OHDEGAR.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

- (c) Subordinate medical officers of central jails.
- (d) Deputy superintendents of lunatic asylums.
- (e) Assistants to civil surgeons at places where they hold these appointments at present.
- (f) Stewards.
- (g) Store-keepers.

The Indian Medical Department officers employed on the civil side should be reverted to the military for six months training every five years or at a little longer intervals.

War reserve.—The war reserve under this scheme will consist of:—

- (a) Indian Medical Service officer in civil employ up to the rank of major or lieutenant-colonel.
- (b) District surgeons of service up to 15 years.
- (c) All resident surgeons of district hospitals.
- (d) All Indian Medical Department officers in civil employ.

In my opinion all the above-named officers should execute bonds to serve on the military side in time of War; and, if need be, they should be brought under military regulations in this matter. Should more men be necessary Government can always depend on volunteers from amongst the private medical practitioners and the medical men in charge of district board hospitals. If I might suggest, volunteers from amongst the private medical practitioners might be trained for three months or so every five years and given a retaining fee or certain privileges.

Answers to questions regarding assistant surgeons and sub-assistant surgeons.

1. Civil sub-assistant surgeons.—Each civil sub-assistant surgeon before entering service has to sign a bond to serve in any part of India under a money penalty of Rs. 400. As far as I know no difficulty has been found so far in enforcing the above condition.

2. It is possible to make the bond renewable before the expiration of the first five years; but I should recommend that each sub-assistant surgeon on entering service on the civil side be asked to give an undertaking not only to serve for five years on the civil side but for a period of ten to fifteen years on the military side in case of necessity.

3. I do not consider the existing conditions of service satisfactory for the following reasons:—

- (a) The designation of sub-assistant surgeon is not a happy one. In fact I do not understand how they can be designated sub-assistant surgeons considering that the vast majority of them do not as a matter of fact serve under the orders of the civil assistant surgeons. I should suggest that they be designated as "Resident Medical Officers."
- (b) The pay given to these officers is very inadequate considering that they have to study for four years, have to pass a fairly strict examination, and that they have much higher attainments than their predecessors of thirty years ago. I should recommend that the pay of this class of officers be from Rs. 50 to 150. The expression "Medical Subordinate" should be done away with, considering that no such expression is used for a corresponding class of officers in the Civil Engineering or any other department.

4. Civil assistant surgeons and sub-assistant surgeons.—During the recent war 11 permanent assistant surgeons, 30 temporary assistant surgeons, 11 health officers and about 156 sub-assistant surgeons were made over by the civil department of this Province for military work without any serious dislocation of the services concerned. The number of sub-

assistant surgeons would gradually increase with the opening of new dispensaries under the new local self-government scheme. During the recent war as far as I know there was no serious dislocation of the services but a few unqualified men, with practical experience, had to be engaged to take charge of smaller dispensaries.

5. Civil assistant surgeons.—In the one-cadre scheme which I have submitted to the Committee, I have recommended that the post of civil assistant surgeon in charge of sadr dispensaries should altogether be abolished; but if some of the graduates of the medical colleges take up service under the district boards, these local bodies should be asked to make it a condition of service that these medical officers would be liable to serve in the military department in case of necessity. To enforce this condition, the service should be made attractive and the men given military rank and pay during the period they remain attached to the military department.

6. I do not think that the ordinary medical requirements of the general population are satisfactorily met by the present arrangements, but those of the State are. More hospitals and dispensaries are required for the rural population. In my opinion the medical officers in charge of hospitals and dispensaries should not be allowed to take fees from those who come to these institutions for treatment. If there are private wards attached to any hospital, the rooms should be marked as Rs. 10, Rs. 5 and Rs. 2 rooms according to the comforts provided in them. I would let people come into these rooms knowing full well what they have to pay per day, and under no circumstances allow any medical officer, no matter what his rank is, to make any stipulation about fees. At the end of the month out of the money collected from these rooms, I would give half to the medical officers concerned, distribute one-fourth amongst the dressers and compounders and retain one-fourth for the benefit of the hospital. At present there is too much tendency to run these private wards as nursing homes for the entire benefit of the medical officers concerned and this is apt to demoralise them and press heavily on the general public.

I do not think that any more paid control or supervision would be to the advantage of the people, though possibly the appointment of members of the independent medical profession as visiting physicians and surgeons might prove of benefit as regards a proper standard of professional rectitude.

7. Military sub-assistant surgeons.—The military sub-assistant surgeon should be the resident medical officer of the Indian station hospital and I think he will do the work very well. Outside the hospital he should be allowed to attend the families of the Indian military officers and also to treat cases in the cantonment bazar, provided he can do so without detriment to his official duties.

8. I am unable to say if the training of the military sub-assistant surgeons is of such a type as is required for military purposes; but I believe it would be advantageous if some special training, as in military hygiene, be given before he is appointed to the post of resident medical officer in an Indian station hospital. In fact I am strongly of opinion that there should be a separate Military Medical School at a central place in India for the training of this class of officers.

9. I am unable to say from personal knowledge how the military sub-assistant surgeons worked during the war as compared with the civil sub-assistant surgeons.

10. Assistant surgeons and sub-assistant surgeons.—The civil assistant surgeons would do exceedingly well as resident surgeons in Indian station hospitals; but I am afraid they will not be attracted to this work unless they are given rank and pay of commissioned officers. The civil sub-assistant surgeons would also do well as resident

26 February 1919.]

Dr. M. N. OHDEAR.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

medical officers in Indian station hospitals and form a war reserve provided they are given better pay and Indian commissioned ranks.

11. *Sub-assistant surgeons.*—I have made my suggestions in the course of my answer to question no. 3.

12. *Military assistant surgeons.*—I do not think that the military assistant surgeons fill any important rôle in a British station hospital or do any work which cannot be done by a trained nurse—man or woman. The military assistant surgeon's displacement or the abolition of this service should not necessitate any increase in the cadre of the Royal Army Medical Corps.

The military assistant surgeon at present, as far as I know, fills only partially the post of a resident medical officer, but works chiefly as a nurse or a trained compounder. He is not allowed to prescribe any medicine or make any alteration, even if necessary, in the prescription written by the medical officers.

13. I am unable to say to what extent the military assistant surgeon relieved the demand for medical men on the military side during the war; but as far as I know only two or three men were

entertained in the civil department in the United Provinces.

14. I am unable to suggest any field for the employment of the military assistant surgeon unless he graduates from one of the colleges and passes a competitive examination as recommended by me in my scheme submitted to the Committee.

15. I am decidedly of opinion that there should be no further recruitment of this class.

16. I am not in favour to recruit the military assistant surgeon class even if the education be raised to the standard required to obtain a qualification registrable in the United Kingdom. Should, however, the military authorities require his services on the military side they might employ him, but he should not be allowed, in my opinion, to come to the civil side except by the door of an open competitive examination as recommended by me in my scheme submitted to the Committee.

17. In the event of his holding a registrable qualification, he might be employed in military hospitals only.

18. If he passes the open competitive examination he should get the pay and privileges as suggested in my all-India one-cadre scheme.

DR. OHDEAR, called and examined.

(President.) He advocated a civil medical service quite distinct from the military service.

He would favour the idea of civil medical recruits going to England for military training, and specialising in certain subjects.

The income of Indian Medical Service officers, as a whole, was much more at present than it had been forty years ago. The only place where the income had gone down was Allahabad. This was due to the late civil surgeon not caring for private practice. The income of an Indian Medical Service officer depended to a great extent on his personality. The number of independent Indian medical practitioners was increasing, but this was only in big stations, not in smaller ones.

He was strongly in favour of the recruitment of Indians in India by means of simultaneous examinations. He had no objection to Englishmen coming out to India to compete with Indians. There were many Indians who held high British qualifications, such as the degree of F. R. C. S., England, and M. D., London. The number of Indians who went to England to study medicine would increase, were is not for the expense involved. The caste system was another obstacle. An Indian did not like to take the risk of failing in his examinations in England and being outcasted from Indian society, although the fear of being outcasted was dying out very much.

He advocated the idea of the civil medical service in India being divided into two classes, senior and junior.

(General Giffard.) Local bodies did not exist in the United Provinces. They had district boards, which had never been independent of Government influence. Each board was supported from Government revenues, Government equalising their incomes according to their needs and varying the grants to each. In the case of districts that had their own medical service, the pay of medical officers would have to be increased, so as to attract the best class of recruits. For poor, jungly districts even, there would be no difficulty in obtaining candidates, as times were very hard at present. The reason why it was found difficult to obtain medical officers for Government service was that there was not enough attraction for the best type of men.

The relation of the service he suggested to the army would be in the senior grades. He had suggested district surgeons and resident surgeons, who would be under military training from time to time. There was a great difference between having military officers in civil employ and having a civil

medical service which was trained for military duties. If they had an entire staff of Indian Medical Service officers, it would cause the country much more expense than if you had an entirely civil medical service. According to his scheme the district surgeons would receive pay ranging from Rs. 800 to 1,200, and you would obtain a good many Indians and Britishers. An officer in England left his home merely for the attraction of the money he could earn in India, which was more than he could obtain in England. He hoped to fill up the cadre of his suggested service by open examination. A separate service would cost the country less money than two services as at present. There was no country in the world where officials were so highly paid as in India. If you increased the military service, the cost in salaries must go up, and the country could not afford it.

An Indian wished to receive equal pay with the European in order to keep up his prestige. The majority of European officers were no better nor worse than the medical men in India, with regard to professional qualifications. By his remark that medical education in Indian colleges was no better, because Indian Medical Service officers did not make it better, he meant that there were many good officers who were unable to impart knowledge. There were others who did not care to teach their students everything. He knew of a case in which a British surgeon in an Indian college told his students that they did not want physicians and surgeons in this country, but only assistants.

Private practitioners should be left alone to form a civil reserve. In the late war, over 45 civil assistant surgeons were taken from the United Provinces. The younger men, if given some sort of encouragement to join military service, would form a military reserve. The encouragement should take the form of military rank, and permission to wear the uniform of their rank even when not on military duty. They should also receive some sort of retaining fee or be made consulting physicians to the district hospitals.

He thought that the term "Sub-Assistant Surgeon" was a misnomer, and was unable to understand the meaning of the expression "Civil Sub-Assistant Surgeon," since 95 per cent. of them were not under any assistant surgeon. The term "Resident Medical Officer" was not a misnomer, as he was resident in all the hospitals and dispensaries. He would, however, have no objection to the name "doctor."

26 February 1919.]

Dr. M. N. OHDEGAR.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

Military assistant surgeons should either be eliminated gradually, or be compelled to obtain a registrable qualification.

(General Hendley.) The reason why he objected so strongly to Colonials coming into the Indian service was because there was no reciprocity between Colonials and Indians. Colonials did not allow Indians to go to their country so why should they be allowed to come to India. Whether qualified in England or in the Colonies he still objected to their being allowed to enter the Indian Medical Service.

The perquisites of Indian Medical Service officers, which he had referred to in his written statement, dated back to 35 or 40 years ago. It took the form of presents known as "Shukrana." The practice was less in vogue at the present time.

He objected to provinces being deprived of the power to revert officers to the military side, without reference to the Government of India, because the local government had a better chance of knowing such officers than the authorities in Delhi or Simla. The power should rest with the provincial government to revert officers, but the latter should have a chance of appealing to the Government of India before being sent back.

He favoured the idea of district hospitals being managed entirely by Government. One reason for this was that, according to his scheme, candidates, after passing the competitive examination, would have to undergo some sort of training before being posted as district surgeons; his second reason was that civil surgeons would have practically nothing to do with hospitals and would be out of touch with their professional work, and they would only be allowed to work in the hospitals by permission of the district boards. He would expect Government to

provide the necessary funds for district institutions. A lot of money would be withdrawn from the district boards for this purpose.

He would debar graduates educated in India from the senior service that he suggested, unless they passed the competitive examination, or if they chose to take up service under a district board.

(General Hehir.) The candidates, who entered the Indian civil medical service, would not necessarily be Indians entirely. His competitive examination provided for 50 per cent. to be recruited in England and 50 per cent. in India. He expected that there would be a large number of Britishers who would come from England to enter the service.

Private practitioners would be attracted to the military reserve if they received uniform and rank, and permission to wear uniform when not on military duty, i.e., on special occasions. There was a certain charm in military uniform which would attract them. The honorary rank of physician and surgeon that he had suggested would be in connection with non-tuition hospitals, i.e., district hospitals, although he saw no reason why even in teaching hospitals honorary physicians and surgeons should not be employed. He cited various instances of Indian doctors, with large experience and practice, who would be suitable candidates for employment as honorary physicians and surgeons in teaching hospitals.

He would not recruit any more military assistant surgeons. Those now in the service who had registrable qualifications should be allowed to continue, and be absorbed as district surgeons or resident surgeons. The rest should be retained chiefly on the military side, and be employed as assistant superintendents in lunatic asylums, assistant surgeons in hill stations, storekeepers, stewards, etc.

DR. S. L. SHARMA, L.M.P., President, All-India Sub-Assistant Surgeons' Association, Meerut.

Written statement.

Q. 1.—Are you satisfied with your present position as an Indian warrant officer? If not, give reasons.

A.—We are not at all satisfied with our present position as Indian warrant officers.

The reasons are:—

- (a) The "Indian warrant officer rank" does not exist in the Indian Army and is therefore meaningless in the case of sub-assistant surgeons. It does not command respect and the sub-assistant surgeon finds it difficult to maintain discipline in the hospital.
- (b) The sub-assistant surgeon remains in the warrant rank till he finishes the 1st grade. By this time an ordinary sepoy, who joined the Indian army as a sepoy along with the sub-assistant surgeon, reaches the jamadar's rank and becomes the sub-assistant surgeon's superior in military rank and demands a salute from him.
- (c) The general educational and professional qualifications combined with the social position of the sub-assistant surgeon demand that he be ranked as jamadar to start with.
- (d) The starting pay of a sub-assistant surgeon, although it is not what it should be in consideration of his educational qualifications, is about the starting pay of a jamadar and this itself entitles him to an Indian commission.

Q. 2.—Do you consider that study periods would be important to your branch of the service, and if so, should they be taken in (a) existing medical colleges, and (b) a proposed new military medical college in India?

A.—Study periods are most essential. The sub-assistant surgeons should get study periods of one year during their service; the military sub-assistant surgeons may take their course in the proposed new military medical college and the civil sub-assistant surgeons in the existing medical colleges.

Q. 3.—Should the local government decide to throw open civil appointments to a large number of military sub-assistant surgeons do you think such appointments will be popular and sought after?

A.—Such appointments will not be popular from a public point of view although the military sub-assistant surgeons would like it. This arrangement is sure to cause a lot of confusion and the civil dispensaries and hospitals will lose their reputation, and the noble cause of alleviating the sufferings of humanity will greatly suffer.

Q. 4.—Do you consider that military and civil sub-assistant pupils should have a higher preliminary school or university qualification than they do at present?

A.—In my opinion the matriculation or the school-leaving certificate examination is the most appropriate preliminary educational qualification for military and civil sub-assistant surgeon pupils. Both the above examinations are in no way inferior to the preliminary educational tests required of medical students by the General Council of Medical Education and Registration in Great Britain.

Q. 5.—What will be the effect on recruiting for the military sub-assistant surgeons' and civil sub-assistant surgeons' classes of demanding a security deposit of money before commencing training which deposit would lapse to Government if the sub-assistant surgeons fail to complete the necessary five years' service?

26 February 1919.]

Dr. S. L. SHARMA.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

A.—The demanding of security deposit of money before commencing medical training would be most unpopular and would adversely affect the recruitment.

The function of the medical schools and colleges should be to impart medical education only, having nothing to do with recruitment as in Great Britain. The recruitment of all services should be done by open competition as in Great Britain.

Q. 6.—Is the bond now signed satisfactory, under which civil sub-assistant surgeons may be drafted to military employ during or after five years' civil service?

A.—The bond system is not satisfactory and should be dispensed with and a special war reserve of civil sub-assistant surgeons be formed by paying a retaining fee to them.

Q. 7.—Is service with the army under present conditions satisfactory to civil sub-assistant surgeons, and if not, what remedies do you suggest?

A.—The service of civil sub-assistant surgeons in the army is not satisfactory under present conditions. The civil sub-assistant surgeons when taken on military duty should be taken with the pay, prospects and privileges of military assistant surgeons and be designated as military assistant surgeons. They should in addition receive the Indian commission up to 1st grade while serving in the Indian army.

Q. 8.—If Government propose that all civil sub-assistant surgeons should undergo a course of military training will this be popular in your department and will it affect recruiting?

A.—A course of military training compulsory to all civil sub-assistant surgeons will not be popular and it will badly affect their recruitment. The military training should only be given to the special war reserve which should be created in the ranks of civil sub-assistant surgeons by paying them a retaining fee.

Q. 9.—Are you satisfied with your present scale of pensions?

A.—Certainly not, so far as field, family, injury pensions are concerned. Half pay of the sub-assistant surgeons' grade in which he was serving at the time of death in the battlefield or in any epidemic may be given to his dependants; and three-fourths in the case of wound and injury pensions.

Q. 10.—Do you consider that there should be a scheme of pensions for widows and orphans of both military and civil sub-assistant surgeons, if so, would the sub-assistant surgeons be prepared to contribute?

A.—There should be a scheme of pensions for widows and orphans of both military and civil sub-assistant surgeons and the sub-assistant surgeons would certainly like to contribute towards it.

Q. 11.—Are there any other specific disabilities in your service which you desire to bring to the notice of the Committee?

A.—There are a number of specific disabilities under which the sub-assistant surgeons' service has been suffering and they are as follows:—

- (a) The curriculum of study in the Government medical schools, where sub-assistant surgeons are trained, is so very defective that they have no prospects of rising to higher grades or to obtain higher medical qualifications. This state of stagnation is incompatible with the healthy growth of the individual and of the profession as a whole. The curriculum of the Government medical schools should be at least so modified as to be similar to the curriculum of the Society of Apothecaries of London and thus made registrable under the British Medical Act. (The Society of Apothecaries imparts four years' medical education in its medical schools like the medical schools of India, recognises practice of one year of

medicine and surgery at a hospital as the five years' training.) Such a modification of the curriculum would open higher posts to the licentiates of medical schools, who at present rot as sub-assistant surgeons all their lives.

- (b) The subordinate service and designation of sub-assistant surgeons be abolished altogether. The subordinate service be merged into the provincial service which should be recruited by competitive examination open to all university graduates and licentiates of medical schools. The Imperial service should also be recruited in India to the extent of 66 per cent. in which the licentiates of medical schools should also be allowed to compete.

- (c) The designation of military sub-assistant surgeons should be abolished and be replaced by "Military Assistant Surgeon." At present there is no class of military assistant surgeons in the Indian army and it is therefore anomalous to have "Military Sub-Assistant Surgeons." They should have Indian commissions from start up to 1st grade and above that honorary British commissions as are granted to the Anglo-Indian military assistant surgeons in the British army.

- (d) The military sub-assistant surgeon is at present a mere clerk. At present in the military employ a sub-assistant surgeon is more a clerk than a doctor. He has to do all clerical work of the medical officer's office. He is not allowed under the rules to prescribe any medicine to his patients which is a source of great heartburning to him and lowering in the eyes of his patients and the army as a whole. It is also generally the cause of friction between him and his officer. Suppose an emergent case comes late at night and the sub-assistant surgeon calls the medical officer; the officer is displeased on account of being troubled at night. If he does not call the medical officer and prescribes himself and unfortunately the case dies the blame lies on the unfortunate sub-assistant surgeon. Thus a sub-assistant surgeon is placed in a very awkward position. If after four years' medical education the sub-assistant surgeon is not considered competent enough to prescribe medicine to his patients in the army, I would appeal to the honourable members of the Committee either to recommend to the Government to raise their standard of medical education or have the above meaningless order cancelled. If a civil sub-assistant surgeon can be placed in an independent charge of dispensary, it is not intelligible to me why a military sub-assistant surgeon is not even allowed to prescribe to his patients. It may be noted here that a civil sub-assistant surgeon is not only placed in charge of a dispensary or hospital, but in certain cases he is promoted to the ranks of assistant and civil surgeons.

- (e) Travelling allowance be sanctioned to military sub-assistant surgeons on escort duty, and a separation allowance be also sanctioned for them.

Q. 12.—Have you any suggestions to make regarding the present method of recruiting for your service?

A.—There should be only one provincial service for the civil and the other for military and both should be recruited by competitive examination open to all university graduates and licentiates of medical schools.

26 February 1919.]

Dr. S. L. SHARMA.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

Q. 13.—As warrant officers have you any difficulty at present in connection with the maintenance of discipline in regimental or Indian station hospitals.

A.—It is very difficult and sometimes impossible to maintain discipline in the Indian army hospitals as a warrant officer.

Q. 14.—What would be the effect on the civil sub-assistant surgeons' service of the wearing of uniform and other military privileges and disabilities that would affect sub-assistant surgeons if they were brought under the Army Act when serving in military employ.

A.—If the civil sub-assistant surgeon be recruited as military assistant surgeons with Indian commission rank up to 1st grade above that with honorary

British commissions and all other rights and privileges of Anglo-Indian military assistant surgeons they would have no objection to put themselves under the Army Act when serving in the military department but they would never like to serve as military sub-assistant surgeons and as warrant officers.

Q. 15.—What would be the effect on the civil sub-assistant surgeons' service and on recruitment for that service of making field service in time of war one of the conditions before the employment in the civil medical service.

A.—There should be no bond nor any conditions for civil men to serve in field service. A special war reserve of civil men be created by payment of a retaining fee to those who offer themselves for military duty or war service.

Dr. S. L. SHARMA, called and examined.

(President.) The witness was the president of the all-India sub-assistant surgeons' association.

(General Giffard.) The sub-assistant surgeons first of all desired that their course of study should be increased from four to five years. They did not want to remain as sub-assistant surgeons and desired to see the class abolished. They should become licentiates and have registrable qualifications.

The students of the medical colleges were admitted after having passed the matriculation or the first science examination. In the United Provinces the matriculates could get a medical degree.

With regard to the remark that in some of the provinces the examination which the sub-assistant surgeons class students had to pass was not considered sufficient to fit them to take a degree even if they had a five years course in the medical college, he suggested that it was merely a technical difficulty, the University having fixed the First Arts as the standard of educational qualifications for admission to the M. B. class. Those who had passed the matriculation or had obtained a school-leaving certificate could very well go into the college if allowed to do so. The University should therefore be prevailed upon to accept the matriculation instead of First Arts examination, as the educational qualification for obtaining a degree. Government had already suggested at the recommendation of the British Medical Council that the matriculation examination might be considered as sufficient. The qualifications which were demanded of students who were granted L. R. C. P. certificates were not higher than the matriculation standard.

Those who became sub-assistant surgeons at present should become licentiates of medicine and surgery.

The course of instruction should be raised to five years and they should be given better pay. Military sub-assistant surgeons should be given Indian commissions to start with that is as soon as they left the school. Their claim for that had been unduly delayed. It was quite true that they would at the age of 23 get the rank which the Indian officers of the army got later in life, but their general education, their professional qualifications and their social status justified the grant to them of jamadar's rank at the very start. There should also be a provident fund for making provision for the widows and families to which they would be willing to contribute.

There was one Society of Apothecaries in London which gave instruction for four years and recognised one year's practice of medicine and surgery at a hospital as the fifth year of training. Such a modification of the curriculum here would open higher posts to the sub-assistant surgeons by making them licentiates.

The subordinate service should be altogether abolished and should be merged into the provincial service which should be recruited by competitive examination open to all university graduates and licentiates of medical schools. At present there were two kinds of service in the United Provinces—the provincial service and the provincial establishment. The assistant surgeons belonged to the former and the sub-assistant surgeons to the latter. These two services should be amalgamated into one provincial service to be recruited as suggested above. As stated in his written statement the military sub-assistant surgeon was at present a mere clerk and had to do all the clerical work of the medical officer's office.

Dr. D. R. RANJIT SINGH, Private Practitioner, Allahabad (Honorary Temporary Captain, Indian Medical Service).

Written statement.

I have no direct or personal knowledge of the Royal Army Medical Corps. I have, however, to offer the following observations about the defects that have struck me in the organization of the Indian Medical Service in India:—

- (a) The recruitment to this service being made exclusively in Great Britain, it keeps back a large number of Indians from competing for this service.
- (b) The Indian Medical Service officers who are appointed on the civil side are so entirely cut off from the army that they lose touch with military matters, which does not conduce to efficiency when they are called upon to do military duties in war time.
- (c) The promiscuous appointment of Indian Medical Service officers to various departments such as professorship in colleges, sanitary department, jail department, lunatic asylums, without necessarily possessing any

special qualifications for the duties pertaining to them does not make for efficiency.

My inability to approve of them arises from the failure to recognise and deal justly with the Indian point of view. They rightly attach importance to efficiency and the needs of the army, but in my view neither of these is incompatible with just recognition of Indian claims.

I consider that the scheme which I submit herewith should meet with the approval of the War Office as I think it will meet the needs of the army in India, provided the War Office take a sympathetic view of the Indian claim.

I consider that my scheme will attract a good stamp of recruits and meet the demand of professional opinion in England and in India.

The result of withdrawing European medical officers from the charge of troops, civil districts and jails in India, has certainly not been disastrous. It may sometimes have caused a little inconvenience until the new

26 February 1919.]

Dr. D. R. RANJIT SINGH.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

incumbents have gained familiarity with the work. Possibly too, some Europeans did not like to have Indians as their doctors. But to the best of my knowledge the standard of efficiency has not fallen notwithstanding the suddenness of this big change. Personally I have had to attend on the wives and children of British officers in my medical charge without ever having given any apparent cause for complaint.

My scheme, I feel, fully meets the needs of the civil administration in India. The experience of the present war has proved that the civil medical administration in India will not suffer during a war if my scheme is accepted.

In my opinion my scheme gives a sufficient and efficient reserve for military purposes.

I consider that it is necessary to have a medical service reserve for war purposes trained in military work and that such reserve should always be actually present in India in numbers adequate to the strength of the Indian army.

The Indian Medical Service did supply a great number of officers for the war. The question as to whether their long and unbroken connection with the civil side had made them rusty for military duties is left to the decision of the high military authorities.

The Indian Medical Service reserve did not supply the whole of the military want as is evident from the fact that over 800 temporary commissioned officers had to be recruited.

In the scheme that I submit are embodied particulars regarding the education and recruitment for the medical officers. In brief the proposal is that every candidate must possess a qualification recognised by the General Medical Council of the United Kingdom. It may even be insisted that the candidate must actually be on its register. Recruitment should be by open competition and the successful candidates should be required to undergo a special training for 6 months at least in a military hospital to be established in India somewhat on the lines of the College at Millbank and then to spend 6 months in the United Kingdom.

In these days of rapid strides of science, it is necessary in my opinion that adequate periods of study leave should be provided for. I would suggest two periods of study leave of 12 months each.

I am of opinion that in a vast country like India more research institutes should be established like the School of Tropical Medicine at Calcutta. The vast region of indigenous drugs has yet to be explored. The present war has proved beyond doubt that India should be independent of foreign countries as regards the production and manufacture of drugs, to the greatest possible extent.

Private practice, in my observation has declined considerably in the case of officers of the Indian Medical Service in the districts and the reasons are:—

- (a) Keen competition between them and independent practitioners who are both more numerous and more competent than they were in the past.
- (b) Improved communications which lead the richer patients to move to central places for treatment by more distinguished physicians and surgeons.

Scheme proposed by Captain D. R. Ranjit Singh, I.M.S., Representative witness of the United Provinces Medical Council before the Medical Services Committee at Lucknow on the 26th February 1919.

(1) THE UNIFIED INDIAN ARMY MEDICAL SERVICE.

(a) *Indian Army Medical Service only.*—The unified military medical service for India shall be entirely the Indian Army Medical Service.

This unified military medical service to be entirely under the control of the Commander-in-Chief in India and his staff officers the Director General of Medical Services.

(b) *Officers. Recruitment, etc.*—The recruitment to this service will be open to all British subjects without distinction of caste, colour and creed provided they are in possession of registrable qualifications recognised by the General Medical Council of United Kingdom and also provided their names are borne on the register of the said Council. Fifty per cent. of the recruitment to be done in India and fifty per cent. in England. The present Royal Army Medical Corps to be dropped as far as India is concerned. The European officer personnel to be put in charge of the British troops and the Indian officer personnel to be put in charge of the Indian troops as far as practicable and possible.

NOTE.—I write this suggestion not because I have any objection to European doctors being in charge of Indians, but because I gather that there is a prejudice against British troops being placed in charge of Indian doctors.

Officers at present serving in the Royal Army Medical Corps in India to be given the option to join the new Indian Army Medical Service and to continue their rank, and their past services to be counted.

(c) *Terms of service.*—The pay and allowances to be the same as contemplated in the Indian Medical Service.

(d) *Promotion.*—The terms for promotion to be the same as at present in the Indian Medical Service including the post-graduate instruction and examination at the Indian Royal Army Medical College (to be established) for the rank of major.

(e) *Hospitals.*—The station hospitals to be combined hospitals, British and Indian, under one commanding officer with a staff commensurate with the dimensions of the hospital.

(f) *Nursing service.*—The present Indian nursing service to be retained as such and to be open to Indian ladies also.

Each hospital to have a fixed establishment of nurses in the usual grades as is customary in hospitals in the United Kingdom.

(g) *Subordinate personnel.*—To consist of the following:—

- (1) *Military Assistant Surgeons.*—The incumbents of this class to be possessed of registrable qualifications recognised by the General Medical Council of the United Kingdom. The racial bar so far rigidly observed in this service should be immediately abolished and the service to be open to all subjects of His Majesty without distinction of caste, colour or race.
- (2) Sub-assistant surgeons as at present with the addition that if they obtain registrable qualifications they should be eligible to be promoted to military assistant surgeons.
- (3) Other ranks of the nursing section including a due proportion of warrant officers and non-commissioned officers, the latter two to be responsible as usual for the discipline amongst the patients in hospital as regards the British troops. The sub-assistant surgeons to be responsible for the discipline among the patients in hospitals as regards the Indian troops.

The sub-assistant surgeons to begin with the lowest rank of an Indian commissioned officer.

(h) *Consulting surgeons and physicians.*—In all big stations, leading local practitioners should be nominated and appointed consulting physicians and surgeons to the station hospitals.

(i) Suitable persons amongst the private medical practitioners to be given honorary ranks as commissioned medical officers and some remuneration in the shape of detention allowance. They will be expected to attend military station hospitals for a specified time in order to keep up the knowledge of working in a military hospital. They should get promotion in their honorary ranks in the same way as the ordinary commissioned officers and should be allowed to use the uniform of their rank on ceremonial occasions.

26 February 1919.]

Dr. D. R. RANJIT SINGH.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

NOTE 1.—A suitable allowance should also be made for the uniforms.

NOTE 2.—All successful candidates competing in India to attend for 6 months the Royal Army Medical College to be established henceforward in a suitable station in India and run on the lines of the College at Millbank and afterwards to spend 6 months in England.

(2) (a) The civil medical service.—There should be a competitive examination for the Indian civil medical service, the same as suggested for the Indian Army Medical Service and the recruitment should be open to all candidates possessed of registrable qualifications again without distinction of caste, colour and creed; in order to provide for an emergency war reserve, every candidate competing for this service should be made to write a bond that he will be liable for military service in case of war and in case of refusal without a proper excuse, will be liable to such punishment as may be prescribed. The successful candidates to be appointed as civil surgeons in the headquarters of districts, the civil surgeons of all provinces to be filled in the following proportions, 25 per cent. by the officers of the Indian Army Medical Service (who will form the war reserve also), 25 per cent. from the promoted civil assistant surgeons, 50 per cent. to be given to the successful candidates in the competition.

(b) Civil assistant surgeons.—Recruitment to be made from the suitable graduates of the Indian medical colleges.

(c) Sub-assistant surgeons as at present with the addition that if they obtain registrable qualifications they should be eligible to be promoted to civil assistant surgeons.

NOTE.—The liability to military medical service having been made compulsory, all the officers personnel belonging to the civil medical service should also be made to attend military hospitals once every 5 or 8 years during the periods of their service. The officers of the civil surgeon class in the civil medical service who are not Indian military medical service men should also be given study leave for 2 periods of 12 months each.

The whole of the civil medical service will be entirely under the provincial government who will have to spare as many officers as necessary during the time of war.

Points of my scheme.

Admitting as I do that the military needs of every country should be placed in the forefront by the devisers of any scheme for the medical administration, no such scheme will ever be looked upon as equitable and just if it fails to satisfy the claims of the children of the soil.

The conditions of the competition and standard of fitness may be fixed as high as necessary but no racial bar or colour prejudice should be allowed to enter in the devising of such a large measure. I venture to think that there is ample provision made for a war reserve provided that the cadres of both the Indian army medical service and the Indian civil medical service would be made large enough to meet the requirements of furlough and study leave, etc., as well as supply the want adequately according to the strength of the army.

Answers to questions about assistant surgeons and sub-assistant surgeons.

1. The bond at present existing for the civil sub-assistant surgeons in my opinion has not proved efficacious. The present limitation to four or five years' compulsory service may advantageously continue. I would, however, add a clause making the incumbents liable to military service up till they are 45 years of age even after the period of the bond has expired.

2. If liability to military duty has been made the condition of service I do not think there should be any more need of renewing the four or five years' bond.

3. In my opinion the conditions of service amongst the civil sub-assistant surgeons are very very far from being satisfactory and I suggest the following improvements:—

- (a) The starting pay should at least be Rs. 75.
- (b) They should rise at least up to Rs. 200.
- (c) In case of transfers to military department substantial allowances to be added to their grade pays.
- (d) In case of transfers again to the military, they should always be given a jamadar's rank to begin with at least.
- (e) A few elected and deserving ones amongst their cadre should be eligible for promotion to higher ranks.
- (f) Two periods of 12 months each should be allowed as study leave to these men also.

4. In my opinion the present cadre of civil assistant surgeon and sub-assistant surgeon is barely enough to meet the civil provincial wants and I think the number employed could indeed very advantageously be increased. The increased number could be very usefully employed both in the hospitals as well as sanitary departments and I venture to think the whole cadre should be safely increased by 50 per cent. There was a serious dislocation of work in some of the branch and mufassil dispensaries where compounders had to be employed to replace the sub-assistant surgeons seconded to military service.

5. I suggest that all civil assistant surgeons should be recruited only when they undertake to serve on the military whenever an occasion arose up till they were 45 years' old. In order, however, to make the service attractive and to get suitable recruits for the service it will be essential to offer much better pay than what they are allowed at present and for this I would suggest the starting pay of Rs. 200 rising to Rs. 500.

6. The present arrangements in my opinion are highly unsatisfactory both as regards meeting the medical requirements of the general population and of the State. I have already mentioned about the increase of cadres. The exact relations of the present day civil assistant surgeons to the hospital of which he is in charge are in my opinion very undefined and vague. Relations between the assistant and the civil assistant surgeons should also be clearly defined. I understand many hospitals in these provinces suffer on account of too much interference of the civil surgeons with the assistant surgeons in professional work. I have been told by old assistant surgeons who were about to retire that throughout their services they never understood as to who out of the two (the civil and the assistant surgeon) was really the treater or the operator of cases in the hospitals: while discussing these points I might as well take the liberty of enlarging on the subject and stating my personal opinion that the whole system of staffing the Government hospitals does not seem to be one which is conducive to the growth of the indigenous medical profession at large. The civil surgeon and the assistant surgeon being allowed free practice and at the same time possessing the advantage of being in charge of hospitals and of its paraphernalia, compete unfairly with the private practitioners; perhaps it would not be exaggeration to say that the hospitals are almost licensed institutions for the benefit of the civil surgeons and the assistant surgeons. To correct all this, the best thing would be to introduce the same system as holds good in the United Kingdom, i.e., to say the Government hospitals should only be provided with resident surgeons and physicians who should get sufficient pay and not be allowed outside practice and the civil surgeon should only be allowed consulting practice. The civil hospitals should be entirely officered by honorary physicians and surgeons, at least in all big stations. The assistant surgeons in small stations where there are no private practitioners should be allowed to practice.

7. The military sub-assistant surgeons should in my opinion be made resident medical officer to the

26 February 1919.]

Dr. D. R. RANJIT SINGH.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

station hospitals and in that case he should not be employed in work outside hospital.

8. The education as imparted in the Agra Medical School in my opinion is not efficient enough to turn out good military sub-assistant surgeons. I recommend that the military sub-assistant surgeons should be trained in an entirely separate military medical school situated in some big military centre. This I am sure will be conducive to better military discipline amongst the military sub-assistant surgeons throughout.

9. I know from personal knowledge that the civil sub-assistant surgeons have always compared more favourably with his military contemporary in matters professional.

10. I have already suggested in the scheme that I have submitted that all civil assistant surgeons should be required to attend military hospitals for a specified time during the periods of their service and this is in view of the war reserve.

11. The pay of the military sub-assistant surgeons should also be increased in the same proportion as has been suggested for the civil sub-assistant surgeons.

12. I have no personal knowledge about this question.

13. I have no personal knowledge of this also.

14. I have no personal knowledge of this also.

15. Indeed the condition of a military assistant surgeon is a most ambiguous and anomalous one; not being possessed of a registrable qualification he is not really entitled to practice and yet he does so by courtesy; the sooner this unsatisfactory system is stopped the better.

16. I would, but I would make one more provision and that is that besides being possessed of a registrable qualification in the United Kingdom he need not exclusively belong to any particular race.

17. They may continue to be employed as they are at present.

18. I have no personal knowledge of this question.

Dr. D. R. RANJIT SINGH, called and examined.

(President.) He was in Government employ and had accepted an honorary commission, and also practised as an independent practitioner at Allahabad, where he had been for 19 years. He had to compete with very old and established practitioners.

He wanted the Indian point of view more considered than it was in any of the schemes.

Private practice had declined in districts and small towns, but not in large cities.

He belonged to the Kayasth class. There was no particular class that entered the medical profession, as they had Brahmans, Khatrias, Kayasths, Rajputs, Muhammadans and others in the medical profession.

(General Giffard.) He thought that the printed schemes were incompatible with a just recognition of Indian claims, because when examinations were held exclusively in England, many Indians were debarred from competing. He did not wish that examinations should be held exclusively in India, but half in England and half in India. Indians who went to England would compete in England. When examinations were held in India, very few Indians would wish to go to England to compete. 95 per cent. of Indians went to England for the purpose of entering the Indian Medical Service.

He had suggested a scheme for the civil service which should be separate from the military, and that civil officers should be transferred to military and should attend military hospitals in order to keep them efficient in military subjects.

There was a deal of difference between civil officers in military employ and military officers in civil employ. Indian Medical Service officers were primarily military. The civil service that he proposed would be obliged to serve with the army only in cases of big wars. They would be trained, but should not be considered military. They should attend station hospitals every

five years, for six months, although he had no objection to this period being reduced.

The military needs of medical officers were entirely separate and different from the civil requirements in every way. An officer, who was in charge of troops, had to deal with a number of men, who were very healthy and lived under much better conditions as regards climate than the civil population; therefore he did not come across the same sort of ailments and diseases as the civil medical officer.

The civil Government suffered by employing military instead of civil doctors through not having control of medical officers in military service. It could not get rid of an officer if it so desired.

(General Hendley.) He was looking forward to the time when Indian ladies would be coming forward in Allahabad to be trained as army nurses. They would be attached to hospitals. They were now attending male cases. All of them were not widows, but a few were. The State Board of Medical Examinations in the United Provinces had now admitted Indian ladies to the nursing examinations. They had been doing nursing work in connection with the Dufferin Hospital, and these Indian nurses not only attended the hospital but were available for private practice and attended male patients. There would be no objection to sepoys being nursed by Indian women, since the British soldier was nursed by women.

(General Hehir.) He had suggested that private practitioners should be made honorary surgeons and physicians in connection with the reserve, and that they should be given a small allowance. The patriotism of the country had risen very high, and many Indians would offer their medical services in time of war. Several leading and senior practitioners in Bombay had been put in charge of war hospitals, and had done useful work.

MAJOR N. D. WALKER, R.A.M.C., D.A.D.M.S. (Sanitary), 5th (Lucknow) Division.

Written statement.

I have been 16 years in the Royal Army Medical Corps, including 9½ in India.

I have no substantial cause for complaint or discontent.

I have never met with any instances of friction between the Royal Army Medical Corps and Indian Medical Service.

I would suggest the following improvements with a view to neutralizing any grievances or friction which may exist: equal distribution of staff billets between the two services; and Royal Army Medical Corps officers serving in India to always have the same grade

pay of the corresponding rank in the Indian Medical Service.

I consider that the following limits of service should be fixed:—

(a) for transfer from military to civil employment—five years.

(b) for transfer from civil to military—ten years.

The most glaring defect which I have noticed in the organization of the Indian Medical Service in India was the regimental system, with the regimental hospital. This has now, I understand, been rectified.

26 February 1919.]

Major N. D. WALKER.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

Scheme A commends itself to me, because I entirely agree with the last three paragraphs of the scheme, more especially the last paragraph. Then again the problem of the Indian commanding Europeans in any way in military service will, I presume, not come in, if an Indian auxiliary corps is formed.

I do not think I am qualified to say what the War Office will say to this scheme but I certainly think it will meet the needs of the army in India. I feel sure, also, that it will attract the right stamp of men and that demands of professional opinion in England and in India will be met by it.

The needs of the civil administration should be met if Indian medical men are forthcoming to enter the civil medical service. In any war such as we have just experienced I fancy the United Kingdom would again have to be drawn on.

The medical reserve must certainly be trained in military work, but need not actually be always present in India.

One has met many Indian Medical Service officers from civil who have run military units very well.

I agree with scheme A and its method of recruitment, everyone to go through Millbank and the Royal Army Medical Corps Depot.

I do not think study leave will be necessary on the military side. The whole-time civil service men to be allowed a period of six months at Home every seven years.

Military assistant surgeons will not be necessary if Royal Army Medical Corps personnel are to be in India as they will replace them.

I take it the cadre of the Royal Army Medical Corps will have to be increased.

The work as resident medical officers that an assistant surgeon now does, except for dispensing and first aid, would be done by the orderly medical officer, as at any military hospital in the United Kingdom.

Many military assistant surgeons actually did Royal Army Medical Corps and Indian Medical Service officers' work during the late war, thus relieving the demand for medical men.

I would let the senior military assistant surgeons do clerical work; promising youngsters should be given the opportunity of obtaining a European qualification. Some might obtain direct admission to the civil medical service if Anglo-Indians as well as Europeans were allowed to compete in the open examination.

I do not think that any further recruitment of military assistant surgeons as at present educated should take place.

I would advocate continuing the recruitment of the military assistant surgeon if his educational standard was raised sufficiently to let him get a grade registrable in the United Kingdom. He would then be able to enter the civil medical service by examination.

MAJOR N. D. WALKER, called and examined.

(General Cree.) He was in favour of scheme A. He saw no objection to officers being seconded to another corps if the conditions of the other corps were good enough. In his opinion it was the pension that appealed to some officers.

(General Hehir.) If the conditions of the proposed new corps were good, there would be some who would transfer permanently from the Royal Army Medical Corps to the Indian Medical Service. If the Royal Army Medical Corps and Indian Medical Service combined they would certainly form a good service.

He advocated the employment of the various sections of the Royal Army Medical Corps rank and file in British station hospitals in India. He would not limit it to the nursing section. He would bring out everybody. The accession of the Royal Army Medical Corps rank and file to British station hospitals would not be compatible with the continuance of the assistant surgeons. They could not be in the same institution. He thought that if the standard of education for assistant surgeons was raised it would only complicate the situation.

(General Hendley.) More medical officers came out to Mesopotamia from England than from India. He thought the United Kingdom would have to be drawn on again for medical officers in the event of another war.

He would advocate an equal distribution of staff billets between the two services, and Royal Army Medical Corps officers serving out here should have the same grade pay as the corresponding rank of the Indian Medical Service.

He did not think an Indian Medical Service officer would make a good Deputy Assistant Director of Medical Service (Sanitary) even if qualified.

(General Giffard.) He was not in a position to say how an Indian officer would work in a combined station hospital.

If the Royal Army Medical Corps were excluded from India there would be no scope for the study of tropical medicine by Royal Army Medical Corps officers.

He did not think that any Europeans would join a service the senior appointments of which were likely to be held by Indians.

27 February 1919.]

Major M. H. THORNELY.

*(The schemes and questions referred to by witnesses are contained in Volume III.)***At Patna, Thursday, the 27th February 1919.**

PRESENT :

THE HON'BLE SIR VERNEY LOVETT, K.C.S.I., I.C.S. (*President*).

MAJOR-GENERAL G. CREE, C.B., C.M.G., A.M.S.

MAJOR-GENERAL P. HEHIR, C.B., C.M.G., C.I.E., I.M.S.

MAJOR-GENERAL H. HENDLEY, K.H.S., I.M.S.

THE HON'BLE MAJOR-GENERAL G. G. GIFFARD, C.S.I., I.M.S.

S. R. HIGNELL, ESQ., C.I.E., I.C.S.

LIEUT.-COL. A. SHAIRP, C.M.G., INDIAN ARMY.

MAJOR M. T. CRAMER-ROBERTS, D.S.O., INDIAN ARMY.

MAJOR A. A. MCNEIGHT, I.M.S. (*Secretary*).

MAJOR M. H. THORNELY, I.M.S., officiating Civil Surgeon, and Superintendent, Orissa Medical School, Cuttack.

*Written statement.**Questions for witnesses.*

The defects I have noticed in the organisation of the Royal Army Medical Corps and Indian Medical Service, are those mentioned in paragraph 16 of the memorandum "Reorganization of the Medical Service in India details connected with scheme C."

Another defect, not I think mentioned in the memorandum, is that many administrative officers have been out of touch with the purely professional side of their work, and have not been ready to consider reasonable suggestions, or back up the demands of keen medical officers, their subordinates. I have had a good deal of experience of military orthopaedic work during the war, and can give details of such defects if required. I have not time now to enter fully into this.

I do not know whether the starvation of Indian regimental hospitals, which was notorious, is due to defects in organisation.

Much dissatisfaction has, I know, been felt by Indian Medical Service officers on account of the treatment they have received in military employ during the war. They have been kept out of posts of position which they were competent to fill, and made to feel that they were inferior to the Royal Army Medical Corps officer.

I. Scheme commends itself to me as likely to remedy the most serious defects. I have not however had time to fully consider all the detail of the scheme and to decide what, if any, alterations it requires.

I am not convinced that it is necessary or desirable to insist on the reversion every five years for six months of all officers allowed to join the civil side. It seems to me that the best employment of the medical officer from the civil reserve in war time is as a physician, surgeon, or specialist; and I doubt whether it is worth while to try to use him in any other capacity, or to spend money and time in training him for such. The military training he is to receive before entering civil should be sufficient to give him a proper understanding of military discipline and hospital administration.

II. If pay and pensions are satisfactory and sufficient money is found for a general raising of the standard of medical service to the troops the scheme should I think meet with the approval of the War Office, and fulfil the needs of the army.

Little is said about the pay of officers. I am doubtful whether officers of from ten to twenty years of service with many or even only a few children requiring expensive education in England will be satisfied with the increase of pay at present promised. I imagine that such officers will still live in a state of constant worry and anxiety as

to how to educate their children in the way they think right and make their income meet their expenditure.

III. It is I think impossible to give a definite answer to this question. The prospects of medicine as a profession during the coming years cannot be foreseen. It depends on what return medicine in the United Kingdom is going to make to the man who enters the profession. If the doctor is going to get better remuneration than before I don't think the new Indian Medical Service will attract the best of the medical schools, unless considerably better remuneration is offered than at present.

Professional opinion in England will not be satisfied unless the administrative heads of the civil medical services are allowed to communicate directly with their Governments, instead of through a secretary many years their junior.

IV. One result of withdrawing European medical officers from the charge of troops has been that a large number of recruits have been enlisted for active service with serious disabilities. I was on the Invaliding Board at Karachi for some time in 1918 and saw only too many sepoys and followers after a few months service returned from Mesopotamia on this account. It was quite impossible for the Board to say that the disability had not been contracted on or aggravated by field service, and a pension was I suppose eventually awarded. The consequent waste of public money must be very great.

Civil Districts.—I have had no personal experience of the results in civil districts. I have been informed however by a magistrate, a Bengali Indian Civil Servant, that he himself much desired the return of Indian Medical Service officers, because his subordinate staff had been so depleted by the granting of medical certificates by the officiating civil surgeon on insufficient grounds.

Jails.—I understand that the mortality in jails in Bihar and Orissa has risen considerably during the last four years, the period during which the province has had only three Indian Medical Service officers as civil surgeons.

V. I doubt whether the civil administration will like the proposal to have a general list for India from which they will draw their commissioned medical officers. Some acquaintance with the language and customs of the people does add to the efficiency of a civil surgeon. I think there should be a general list for the teaching, medical college and specialist appointments.

I see no way of avoiding the undesirable consequences of withdrawing many medical officers in time of war on a large scale. But the civil cadre will be I take it larger than it is at present—it loudly calls for expansion, and

27 February 1919.]

Major M. H. THORNELY.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

the establishment of the special reserve should relieve the strain.

VI. I have not the necessary knowledge to answer this question.

VII. I consider it is necessary to have a medical service reserve for war previously trained in military work, and that a reserve having the necessary knowledge of India can only be found in India.

VIII. As the majority of officers forming the reserve (Indian Medical Service, civil side) have possessed knowledge and a practical experience of medicine, surgery and their special branches considerably larger than the majority of Indian Medical Service men who have remained in military employ, it seems obvious that they must have proved of great value in the war. I am of opinion however that their special knowledge has not been put to the best use. In my experience it has been too often the custom to regard one medical officer as the same as another, except for purely administrative appointments, and to forget the desirability of putting the right man in the right place.

IX. The system advocated in scheme C seems generally satisfactory. I presume that the present rules for encouraging recruits to obtain post-graduate training before entering the service will still hold, as they should.

X. I have no suggestions to make regarding the study leave rules. They are I think generally satisfactory.

XI. I have no suggestion to make regarding the provision of a special department of research.

XII. I cannot say how far private practice in the Indian Medical Service has declined in Bihar and Orissa. I never made more than an average of Rs. 250 a month until last year. There are only three or four stations in this province I believe where more can be made, if the Indian Medical Service civil surgeon limits himself as he should do to being a general practitioner for the European families, and a consultant for Indian patients. If he likes to compete as a general practitioner with the assistant surgeons by taking smaller fees from Indian patients he could make more but this in my opinion should be strictly forbidden.

Questions to be asked of service officers.

1. Military Service.

	Years.	Months.
From January 1900 to June 1902	6	2
October 1914 to June 1918		
Civil—		
January 1902 to October 1914	12	11
June 1918 to February 1919		
TOTAL	19	1

2. I have substantial cause for complaint and discontent.

(1) Pay.

Whilst the cost of living in India and England has continued during the last 19 years to steadily rise so that the rupee now purchases what I believe eight annas did, and the shilling less than what six pence did in England, when I entered the service, practically nothing has been done to compensate Indian Medical Service officers for this. The pensions are now for the same reason inadequate.

(2) Treatment whilst in military employment between 1914 and 1918.

(a) I contracted illness on field service in Egypt at the end of 1914 and was on sick leave for about 18 months. During the whole of this time except for a few months when I was working at the Kitchener Indian Hospital, Brighton, I was kept on pay of £450 a year, £50 a year less than if I had been on furlough under the civil rules.

(b) I was passed as fit for duty in England, after returning from Egypt and a period of convalescence in England, and the India Office asked the War Office to give me employment. Civil practitioners and officers in other services in similar circumstances were given suitable work for short periods at once. Apparently because I belonged to the Indian Medical Service I was refused employment by the War Office.

(c) I recognised the importance of military orthopaedic work and took up its study in 1916 at the request of the India Office and in communication with Surgeon-General Sir Havelock Charles. I wrote several notes on military orthopaedic work in England with suggestions for the work in India. The India Office later recommended to the Government of India that I should be employed on this work on my return to India. I returned to India in November 1916 and it was not until May 1917 that I was put on to military orthopaedic work. Between November 1916 and May 1917 I was in medical charge of an Indian regiment at Baroda, doing work which any junior Indian Medical Service officer without special knowledge could have done.

(d) During the year that I was at Karachi organising and looking after the orthopaedic section of no. 37 Indian General Hospital, and part of the time being in addition in charge of a division of 500 beds. I received pay of Rs. 900 a month and Rs. 60 specialist allowance. I consider that the pay in military service is much too small and that there is a great want of justice in apportioning the allowances. Nor was any consideration given to the grievance that we all suffered from the extremely high cost of living in Karachi.

3. An instance of friction is given in my answer to question no. 2.

4. I have no improvements to suggest.

I think scheme C should remove friction. The removal of grievances depends on a satisfactory application of the scheme in regard to pay, allowances and pension.

5. (a) I have not arrived at a decision. I am of opinion that for the majority of officers service in civil (after five years' preliminary military training) should be permanent.

(b) Six months.

MAJOR M. H. THORNELY, called and examined.

(President) He had had 19 years' service; and from 1914 to 1918 had been on war work.

He was in favour of either scheme B or C, although in his written statement he had mentioned scheme C only.

The suggested increase of 33½ per cent. to the pay of Indian Medical Service officers was not sufficient to attract recruits to the service. He advocated an increase of 50 per cent. He also favoured, as a further attraction, more liberality in the matter of leave.

(General Giffard.) It was not advisable to exclude the Royal Army Medical Corps from India, as you must have Royal Army Medical Corps officers in India for British soldiers. The Royal Army Medical Corps officer

had an extended experience on account of having been to other parts of the world, and from the Imperial point of view it would be better to have them. He did not, however, see any way out of the difficulty of their having eventually to serve under Indian officers of the Indian Medical Service.

If the Indian Medical Service was to be made habitable for Europeans, they would want the certainty of coming into civil service and staying in civil. It would not be satisfactory to be transferred backwards and forwards from civil to military and military to civil. The best employment for a civil officer in war time was as a specialist. He should, however, decide at some period of his career whether he elected to remain permanently

27 February 1919.]

Major M. H. THORNELY.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

in civil or permanently in military. If he decided to remain permanently in civil, he would, in war time, come back to the army as a specialist.

(*Mr. Hignell.*) He agreed that scheme C was simply an improvement on the existing conditions of the medical services in India.

(*General Hendley.*) Military training for civil officers could not be performed without dislocating the work of the civil department. He should suggest military training twice for six months, not more. He would give the two periods of 6 months, after the first five years, and after the second; and after 15 years, though better 10 years, an officer should elect whether he would remain

permanently on the civil side of the service or on the military.

(*General Hahir.*) He had only civil pupils in his school. They did not get any physical training, although he agreed that it would be a good thing for them.

He would advocate making study leave for Indian Medical Service officers compulsory, though he would leave it to the initiative of the officer taking the leave as to the length of time it was necessary for him to have, in pursuance of the special branch that he wished to study.

When employed as a civil surgeon he was not satisfied with his position, as he was underpaid and overworked.

DR. G. W. THOMPSON, Chief Sanitary Officer, Jheriah Mines, Board of Health, Dhanbaid.

Written statement.

I am of opinion that the whole medical work of this country cannot be carried out under one administration and for that reason I prefer scheme C.

I would however go further and suggest that the work of preventive medicine is so vast, of so complex a nature, and of so much importance, that any scheme is deficient which does not make provision for an adequate service of experts specially recruited and employed for the carrying out of preventive measures against disease.

Sanitary medical science in which I am most interested, receives scant attention in these schemes. It is not mentioned in scheme A, C or D. In scheme B, "sanitary appointments" are referred to in paragraph 17, while in the paper dealing with the details connected with scheme C, a brief paragraph no. 18, deals with the whole problem and suggests that the department should be open to the whole of the two proposed services, i.e., presumably closed to all other sources, a suggestion which, if adopted, is calculated to perpetuate the evils of the past.

In the time at my disposal, I can do no more than summarise the arguments in favour of a separate sanitary service, and leave the elaboration to others. The following facts occur to me:—

- (1) That more than 75 per cent. of all sickness or mortality in this country is due to preventable causes.
- (2) That the majority of the diseases which cause this terrible state of affairs, have been partly or wholly controlled in many civilised countries.
- (3) That outside the larger cities, except in the case of special organisations, e.g., the army, sanitary measures may be stated for all practical purposes, to be non-existent.
- (4) That in spite of Government pronouncements and the warnings of eminent medical officers in the services, nothing practical has been done and the condition of the general population, as regards the record of cholera, smallpox, malaria, remains as high as ever, while infant and child mortality statistics show no improvement.

Nothing can or will be done until the public and the administration recognise that the work of sanitation should be directed and controlled by persons who have undergone special training in sanitary science.

In view of this serious condition of affairs the following queries arise:—

- (1) Is a separate sanitary service necessary?
- (2) How is it to be organised?
- (3) How is it to be recruited?

If it be conceded that the work of preventive medicine in this country is of so much importance, and that, for its successful accomplishment specially trained men are

required, it is difficult to answer the first question in any other way than in the affirmative.

With regard to the second question, it appears to me that local authorities should exercise the executive control, but should be advised by the central Government, as is the custom at present in Europe.

This might be effected by organising a special sanitary corps. The personnel should be recruited from all sources available, and indeed this is suggested in scheme C, paragraph 38. A higher age limit than required for the general services will be necessary.

The title "Sanitary Commissioner" should be abolished. The designation should be changed to "Director of Public Health." The special duty of the Director would be to co-ordinate the work of the staff employed under him. Bacteriologists and chemical analysts would form a portion of the staff of the sanitary service, but these should be specially recruited and should not be interchangeable with the extra-laboratory staff.

As regards the third question, the present system of recruitment has given rise to many evils, and demands sweeping reforms. That such evils have existed may be judged from the following facts:—

- (a) It is admitted that those taking up sanitary work were often the less competent officers of the Indian Medical Service.
- (b) Frequently these officers were appointed against their wish.
- (c) Many of them were, at best, amateur sanitarians.

I would suggest that if a separate sanitary service be constituted, these evils would be largely, if not entirely, eliminated. Every officer would, of necessity, have to possess a Diploma in Public Health before joining the service, and this would, to a certain extent, insure that he possessed the true inclination for sanitary science. If the terms of recruitment were such as to attract capable candidates, it would secure an adequate corps of sanitary experts. The personnel of this service would consist largely of Indians, and the anomaly of fixing the same emoluments for posts whether held by persons domiciled in India or abroad should be removed.

The salary of the posts should certainly be the same in each case, with a proviso that a European should receive a substantial allowance to compensate him for the additional expenses necessitated by maintaining separate establishments in this country and elsewhere. A free passage Home and out should be granted every three years, thus removing the ground of expense as an excuse for not taking regular leave. It is impossible for the majority of Europeans to spend protracted periods in India without necessarily impairing their efficiency, and especially in the case of scientific workers.

Study leave.—This should be on a general scale. Many officers when on furlough would be only too glad to devote a portion of the time to improving their knowledge and experience.

27 February 1919.]

Dr. G. W. THOMPSON.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

For military purposes, the formation of a sanitary corps, possesses distinct advantages. If the members of such a corps seconded from time to time for military duty, a most important reserve of experts in sanitation would be available for active service. It should be dis-

tinctly laid down however, that such officers are not to be attached to military units in the capacity of regimental officers, but for the special work connected with the prevention of disease and the preservation of health.

Dr. G. W. THOMPSON, called and examined.

(President.) He had been in India for 6½ years. He came out on an engagement with the South Indian Railway. He had been with them for two years and nine months. Since then he had been in his present appointment. His pay was Rs. 1,200 rising to Rs. 1,500. He was in favour of scheme C. He was also in favour of a separate sanitary service. He would not make this sanitary service a portion of the general medical service. It should be a provincial service.

(General Giffard.) He thought that good European doctors would come out to this country if the emoluments offered were attractive. He did not think many students would come into the service if they were put on an equality with Indian doctors. He was very sanguine about the growth of the independent medical profession.

He did not think that planters, railways, and collieries employed as many European medical officers as they should. They employ an Indian substitute but he is not

of the right type. They generally employ a sub-assistant surgeon on about Rs. 100 a month.

(General Hendley.) There were no rules on the subject of appointing any particular kind of medical doctor. The planters, railways, etc., can appoint anyone they like.

(General Hehir.) He could not give a reason for not entering the Indian Medical Service. He had really never given it a thought. He had decided to take up public health. He was always interested in the scientific side of medicine.

(General Cree.) With regard to the sanitary service being an Imperial service he was of opinion that it would be better if it was local, as the problems of sanitary work were very much bound up with districts. He had no objection to the corps being an Imperial one, provided that it was administered by the local government.

Dr. S. M. LIVESAY, officiating Civil Surgeon, Darbhanga.

*Written statement.**Questions for witnesses.*

- (1) (a) No answer.
- (b) Scheme A is I consider the best; as this gives one military medical service in India, and so stops all friction.
- (2) I think so.
- (3) It should.
- (4) No answer.
- (5) Yes; with the modification I suggest.
- (6) Yes.
- (7) It is advisable but not necessary.
- (8) No answer.
- (9) The standard of medical education for admission should be as at present, and recruitment should be from the Home and Australian medical schools.
- (10) I think special study leave should be given every five years.
- (11) All the main hospitals, and medical schools should have special department for research.
- (12) I understand it has declined; and the reason I believe is that the public considered the fees too high.

Special questions.

- (1) I think predilection had some influence but I consider professional merit counted most.
- (2) Not satisfied; they have met the difficulty by calling in the nearest European medical officer.
- (3) Their efficiency is moderate in the senior grades, poor in the lower grades.
- (4) I should say have improved.

Modification suggested for scheme A.

I suggest the following modifications, as I consider the scheme does not give sufficient encouragement to the independent medical profession in India:—

- (1) Local governments should make provision for Sanitary, Jail, Bacteriological, etc.
- (2) District boards should appoint medical officers for their district subject to the approval of the local governments. These appointments should be open to the whole of the medical profession.
- (3) Professorship, hospital staff and allied appointments should be open to the whole medical profession as in other colonies; this would ensure getting the best men and infusion of new ideas.
- (4) I think there can be no question that India requires a large body of well qualified medical practitioners. If district and other appointments were thrown open to the whole profession, that is by creating the demand, India would soon get a good supply of well qualified medical men. Arrangement could be made by which the independent profession could undergo the necessary amount of periodical military training.

This scheme has a double advantage. It would stimulate the Indian Medical Service officers to greater efforts to have the keen competition of the independent profession and it would ensure a better class of medical practitioners in India and give a better reserve for military purposes.

Dr. S. M. LIVESAY, called and examined.

He had qualified in 1905 and had come out to India as an independent practitioner in 1913. He applied to the Government of India for an appointment at the outbreak of the war, and was given a district in March 1915. He was quite satisfied with his present appointment which had nothing whatever to do with the Darbhanga estate.

It was on the advice of a friend that he did not enter the Indian Medical Service. His friend told him that he did not think any service gave a man a good opening.

(General Hendley.) His actual pay was not less than Rs. 1,700 a month. Government paid him Rs. 800. He also had private practice. He received no pension.

27 February 1919.]

Dr. S. M. LIVESAY.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

He was strongly of opinion that the best men would be got for the professorships in India if the appointments were thrown open to the whole profession.

He thought that Europeans coming out to India would require at least Rs. 1,500 a month to start with and consulting practice. The best age for them to come out would be 30.

(General Giffard.) If all the appointments were thrown open to the medical profession a greater number of European medical men would be forthcoming. It was

really the pay that mattered. If the pay was attractive there would be no difficulty in getting good men. The prospect of serving under Indians would however deter men from joining the service.

He had not thought out how leave and sick leave vacancies were to be filled if there was no Government service.

He did not know how men were to gain experience in tropical diseases before coming to India. He had not grasped the difficulties that would arise when his proposals were put into practice.

Civil Assistant Surgeon PREMA NANDA DAS, officiating Civil Surgeon, Puri.

Written statement.

I have answered those questions only which are within my personal knowledge. I have not touched questions beyond my personal knowledge and experience.

1. After considering all the schemes for the re-organisation of the medical services in India, I am decidedly in favour of scheme C with some modifications. The scheme fulfils more than any other the objects of the re-organisation namely, provision of an adequate State military medical service in times of peace, reserve for war purposes, and attempts to remove the present grievances of the Indian Medical Service, and to meet the demands and aspirations of the Indians. The system of recruitment and education for the military medical service is in my opinion capable of further improvements from a popular standpoint as well as from considerations of efficiency. So far as military surgery is concerned, pre-war knowledge is more or less obsolete in the light of the tremendous wealth of information and experience the profession has acquired in the great conflict. The conditions of modern warfare therefore demand a high standard of up-to-date knowledge of advanced military surgery, advanced radiography, bacteriology and public health. These are the subjects in which Indian medical education is more or less incomplete. In the competitive examination for recruitment one of the four subjects should form a special subject on which great stress and importance should be laid, and the candidate should be supposed to specialise in one of the subjects. Increased efficiency will necessitate concomitant increase of remuneration. I do not consider myself competent to express any opinion on the pay of the proposed military medical service, but I think, so far as my knowledge goes, that many Europeans with no university education draw higher pay in the various mills in India than a major in the Indian Medical Service.

2. There is no provision in the proposed Indian military medical service for recruitment from selected and willing civil assistant surgeons. In place of selecting Indian raw and inexperienced university graduates and sending them to Great Britain for competitive examination and social training as proposed in scheme B, I am of opinion that willing civil assistant surgeons of 3 to 5 years' standing selected in consideration of merit, ability and activity, and who have displayed special aptitude for work, may be sent up for competitive examination, if such a proposal is accepted. Academic career and aptitude for work are not always co-existent. On the other hand civil assistant surgeons who are willing to serve with troops and work in station hospitals and are satisfied with the rank of a non-commissioned officer may be allowed to do so and this class may be requisitioned for in time of war. If civil assistant surgeons' service constitutes a rung in the ladder of the higher grade of service within legitimate limits, it will undoubtedly attract young men of the best class. As regards the proposed civil medical service I am of opinion that recruitment in the uncovenanted medical service should be made irrespective of nationality only in cases of exceptional merit and ability high European qualification and social training being indispensable conditions, otherwise the prestige of the service

will suffer in the estimation of the public both European and Indian. Such recruitment will be an encouragement to private practitioners both European and Indian and will be a popular measure.

3. I am in favour of promotion of civil assistant surgeons to the higher grade of civil medical service provided selection is made on considerations of ability, administrative capacity, merit and activity, qualification and professional knowledge, after completion of a specified period of service, as in the other sister provincial services namely Forest, Excise, Police and Executive, etc. Selection at the far end of the service of an Indian officer is apt to defeat its own object and is detrimental to the efficiency of public service and is apt to lead to failure and ridicule. Unless there is legitimate and reasonable opening for able and qualified men, the personnel of the civil assistant surgeons' service is bound to be poor and the service will fail to attract good men.

4. I have no experience of the results of withdrawal of European medical officers from charge of troops. So far as the professional work—surgical and medical—in a hospital goes I believe that the facts and figures do not warrant the conclusion that there has been any general deterioration of the standard of work. On the other hand it is within my personal knowledge that the professional work done has excelled any previous work on record in some district hospitals in this province.

In India the temporary nature of responsible high post and the salary it carries (when held by an Indian) are factors which have a great bearing upon the maintenance of discipline, and if efficiency of jail administration has suffered in some cases, I am of opinion that partly the aforesaid factors and partly the inexperience of the officers in that special branch of executive work to which they had not been accustomed before, are responsible for it. On the other hand it is within my personal knowledge that in some districts administration of the jail has decidedly and definitely improved and the fact has been officially recorded by the Head of the Department.

5. I am of opinion there should be a research department connected with the medical institution of the head quarters of this province, and officers should from time to time be deputed to investigate the prevalence of endemic diseases peculiar to this province.

6. I do not think that surgical practice of the officers of the Indian Medical Service has declined. The excellent surgical work by the members of the Indian Medical Service is very much appreciated by the public all over India. The decline of medical practice, if there has been any, is probably due to the presence of retired and senior practitioners in almost every town whose scale of fees is very much lower than that of the members of the Indian Medical Service.

I understand that there has been restriction in the scale of fees for medical attendance on Feudatory Chiefs and Rajahs by members of the Indian Medical Service in case they have to leave station for such purpose. If legitimate channels of income are shut off, professional enthusiasm is apt to run dry.

27 February 1919.]

Civil Assistant Surgeon PREMA NANDA DAS.

{Continued.

(The schemes and questions referred to by witnesses are contained in Volume III.)

7. I do not see any objection to the proposal for obtaining supplies of medicines from Government Medical Store Depots in case of local fund institutions, provided the duty of prompt payment is impressed upon the local authorities who should be clearly given to understand that no indefinite postponement of payment will be allowed as occurs in some cases at present.

8. I have no knowledge of the attitude of the Europeans on medical attendance by Indian substitutes, beyond my personal experience which extends over two years now, in a station where I had ample opportunities of treating a large number of European ladies and gentlemen. I have not been led to believe that the attitude of the Europeans is based upon racial bias. I am an Indian. I have always found the Europeans considerate and appreciative in my professional capacity. It would be idle to deny that they prefer Europeans but it is unfair to say that they are not satisfied with a duly qualified Indian "at Home" possessing good manners which are the outcome of social training. My professional connection with the Europeans has been always of a pleasant and happy character.

9. I have already answered some of the questions for the civil assistant surgeons and have also detailed some of the disabilities of the provincial civil medical department. I am of opinion that the extension of the privilege of study leave to the teachers of the medical institutions to enable them to specialise in their respective subjects, will improve medical education in India. The treatment of masses in India so far as western scientific treatment is concerned, is carried out by doctors who qualify from medical schools. The more practical this education is, the better for the masses in India.

I am of opinion that the personnel of the teachers of the medical institutions should be borne on a separate cadre with prospects of a better and higher opening though they may be initially selected from civil assistant surgeons.

DR. P. N. DAS, called and examined.

(President.) The witness was a civil assistant surgeon and had obtained the F.R.C.S. degree at Edinburgh and was at present officiating as civil surgeon, Puri. He had a total service of 18 years and had taken the above degree after 13 years' service.

He was in favour of scheme C with certain modifications indicated in his written statement. Some provision should be made for admitting selected civil assistant surgeons to the Indian military medical service. As explained in his statement, instead of selecting raw and inexperienced Indian university graduates and sending them to Great Britain for competitive examination and social training, willing civil assistant surgeons of 3 to 5 years' standing should be selected on considerations of merit, and allowed to enter for the competitive examination.

The decline in medical practice of the Indian Medical Service, if any, was due to the presence of retired and senior practitioners in almost every town, whose scale of fee was very much lower than that of the members of the Indian Medical Service.

(General Hendley.) Some junior civil assistant surgeons might be willing to serve with Indian troops and in Indian station hospitals as non-commissioned officers.

So far as my personal knowledge goes, many of the teachers of the medical institutions of the various provinces in India possess the highest qualifications of Great Britain or India and I do not consider that it will be fair to relegate them to one common category and status with no better prospects of promotion in the higher grade of service than the other officers of the same cadre. I would like to add that the teachers should be given greater facilities for practical work in hospitals in their respective subjects.

10. I do not think the appointment of military assistant surgeons to a large number of civil posts at present occupied by civil assistant surgeons will be a popular measure. Apart from other considerations undesirable friction may arise with regard to lucrative posts leading to much heart-burning on both sides.

11. Some junior civil assistant surgeons may be willing to serve with Indian troops and in Indian station hospitals as non-commissioned officers. It will mean a great pecuniary loss to senior civil assistant surgeons to serve with troops and in station hospitals unless in the substantive rank of a commissioned officer.

12. I do not see any necessity of fixing a probationary period for civil assistant surgeons as proposed in scheme C so long as utilization of the best talent is made irrespective of class or racial interest.

13. I am not in favour of the abolition of the written portion of the septennial examination for civil assistant surgeons, but I am at the same time of opinion that the questions should pre-eminently be of a practical nature.

14. Civil assistant surgeons on recruitment, may be asked to sign an agreement to serve in the military department for a period of five years, in case of necessity. It is difficult to say that this measure will have a good effect upon recruitment unless special consideration is made for their military service.

They should be appointed to these posts after 5 years' service. They would be satisfied with temporary commissions. There would be some difficulty about the pay as they would not be satisfied with the pay they were getting in the civil department. They should get at least Rs. 300 a month during the first two or three years of service.

There was no friction between assistant and sub-assistant surgeons in Bihar and Orissa.

He was not in favour of the abolition of the sub-assistant surgeons and thought that they served a very useful purpose. They should be retained as at present.

(General Hehir.) Assistant surgeons and sub-assistant surgeons would voluntarily form a war reserve after a period of about five or six years' service. If joining such a reserve were made a condition of Government service it would not affect recruitment, but it would be better if some consideration were shown to those who volunteered. They might be given good posts on return from military duty, and they might also be granted commissions.

Personally he would like the idea of getting military rank and wearing uniform, but this consideration would not generally weigh with senior men.

28 February 1919.]

Colonel G. J. H. BELL.

*(The schemes and questions referred to by witnesses are contained in Volume III.)***At Patna, Friday, the 28th February 1919.**

PRESENT :

THE HON'BLE SIR VERNEY LOVETT, K.C.S.I., I.C.S. (*President*).

MAJOR-GENERAL G. CREE, C.B., C.M.G., A.M.S.

MAJOR-GENERAL P. HEHIR, C.B., C.M.G., C.I.E., I.M.S.

MAJOR-GENERAL H. HENDLEY, K.H.S., I.M.S.

THE HON'BLE MAJOR-GENERAL G. G. GIFFARD, C.S.I., I.M.S.

S. R. HIGNELL, Esq., C.I.E., I.C.S.

LIEUT.-COL. A. SHAIRP, C.M.G., INDIAN ARMY.

MAJOR M. T. CRAMER-ROBERTS, D.S.O., INDIAN ARMY.

MAJOR A. A. McNEIGHT, I.M.S. (*Secretary*).

COLONEL G. J. H. BELL, C.I.E., I.M.S., Inspector-General of Civil Hospitals, Bihar and Orissa.

Written statement.

SCHEME C.

RE-ORGANIZATION OF THE MEDICAL SERVICES IN INDIA.

Points of difference between proposed scheme and present organization.

(a) There appears to be no objection to changing the designation to Indian Medical Corps, but I fail to see the need for it.

(i) Apparently necessary.

(ii) I do not see why Royal Army Medical Corps officers should be permanently transferred to the Indian Medical Corps.

(iii) I also fail to see why they should be seconded into the Indian Medical Corps, but I suppose there would be no other alternative if the proposed Indian Medical Corps is to be in medical charge of both British and Indian troops. For the same reason, apparently, the Indian Medical Department (old Indian Subordinate Medical Department) would require to be incorporated in it.

(b) The increase would evidently be necessary.

(c) I think too that this would be necessary.

(d) I do not think that a tour of civil duty for five years only would be satisfactory from the point of view of the civil medical administration. It would involve too frequent changes, which even now are very frequent.

I do not approve of officers of the rank of lieutenant-colonel being transferred to military or being made to remain in military altogether. In the first contingency the civil department would suffer by the loss of their most efficient officers and in the second the military department would apparently also suffer by the services of these officers not being available for military duty, especially in time of war. The course of training referred to might be extended to six months. In my opinion this would be ample.

(e) I agree that all officers of the Indian Medical Corps who are in civil employment should form a *war reserve*. This is practically as at present. I do not, however, agree to the exclusion of those who have reached the rank of lieutenant-colonel from this reserve. As regards so-called indispensable appointments, such appointments must be few, and it would seem to be a mistake to exclude the officers holding them from the available reserve.

As regards the *special reserve* it is not clear as to how this is to be formed from European, Anglo-Indian and Indian medical practitioners. It would apparently be necessary to give a retaining fee. The case of civil assistant surgeons is different. Liability to military

service up to a certain grade or age should be made a condition of their appointment as is already the case with civil sub-assistant surgeons. I have never been able to understand why the latter class should have been made liable and not the former. I would go further, and say that all medical men employed and paid from local and municipal funds should, as a condition of their appointment, be made liable for military duty as is now the case with civil sub-assistant surgeons. The gradual substitution of local fund employes (local Indian doctors) for Government sub-assistant surgeons is obviously reducing the war reserve of this class, and it is impossible to say where this will end. The question of *Home reserve* seems to be doubtful from a practical point of view.

The expansion of the civil assistant surgeon class and of the cadre of sub-assistant surgeons in civil employ is, I consider, very necessary.

(f) Such a college would be very useful, but possibly it could be more advantageously constituted by utilizing existing large civil general hospitals rather than by forming a separate Indian Medical Corps College.

(g) An increase in the number of specialists seems to be desirable, but it would be necessary, I think, to ensure that these specialists should be men of experience and not merely that they should have gone through some special course and passed a special test.

(h) I can see no objection to opening the administrative appointments in civil to the whole Indian Medical Corps officers. In fact this seems to be the existing practice to a great extent judging from recent appointments which have been made. I understand that the old divisions of the service into Bengal, Madras and Bombay have been abolished and are only at present applicable to senior men.

2. I understand that the two medical services referred to would be much as they are now.

3. As far as I am aware the two administrations are at present to some extent complementary, but I agree that the degree of relationship should be increased, as I have already remarked by making liability to military service on all grades of medical officers in the employment of Government and of local bodies compulsory.

A.—THE INDIAN MILITARY MEDICAL SERVICE.

4. *Organization*.—I am not sure of any need for the change in name, but it seems to be not of very much importance by what name the service may be called.

5. No remarks.

6. With regard to (e) (ii) and (iii) and (iv) I have already noted under paragraph 1 (a) (ii) and (iii).

28 February 1919.]

Colonel G. J. H. BELL.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

7. If a Corps be formed the composition would probably have to be as stated.

8. No remarks.

9. No remarks.

10. I think that it would be very rarely, if ever, the case that the need for nominating a Director Military Medical Services from the Army Medical Service will arise and therefore the necessity for this proviso is not obvious.

11. This is a question of administrative detail.

12. No remarks.

14. The ratios proposed seem to be appropriate.

15. No remarks.

16. Possibly if an Indian Medical Corps be formed, the inclusion in it of Royal Army Medical Corps officers by seconding them seems to be unavoidable but I do not think that they should be permanently transferred to the Corps.

17. See 16 above

18. No remarks.

19. I do not think that seconded Royal Army Medical Corps officers should do duty with Indian troops, nor do I think that they should be allowed to transfer permanently to the Indian Medical Corps.

21. I doubt if the number 450 is sufficient. I have noted on this under scheme B, paragraph 4, where the correct number would seem to be 672. This is, however, a matter for calculation.

22. No remarks.

23. I cannot agree with this.

24. I doubt the need for this.

25. A course of six months should be ample.

26. I am doubtful as to the advisability of an examination for promotion to lieutenant-colonel.

27. I cannot see the object in including combatant officers on the proposed promotion board.

28. I can see no objection to promoting selected military assistant surgeons as proposed.

29. No remarks.

30. No remarks.

31. I have already noted on this under paragraph 1 (e).

32. I have already noted on this under paragraph 1 (e).

33. No remarks.

34. }

35. } I agree.

36. }

37. I doubt if assembling of all branches of the rank and file of the reserve once a year for training would be feasible. I would suggest that once in three years would be more practicable. A retaining fee would be necessary.

38. I have already noted on this under paragraph 1 (g).

39. *Specialists in military employ.*—I doubt if there is sufficient reason for the appointment of consultants.

40. *Indian Medical Corps College.*—I have already noted on this under paragraph 1 (f).

41. No remarks.

B.—THE CIVIL MEDICAL SERVICES OF INDIA.

42. *Organization.*—No remarks.

43. The present organization, administration and conditions as a whole may remain, but probably increases in cadres all round are required for thorough efficiency.

OFFICERS OF THE CIVIL MEDICAL SERVICE.

(i) *Head of the Civil Medical Service.*

44. I agree. Four years seems to be long enough for a tour of service, especially considering the somewhat advanced age at which an officer can hope to reach the post of Director-General.

(ii) *Surgeons-General with the Governments of Bengal, Madras and Bombay.*

I agree generally, but do not think that the nomination of the candidate should be left to the Government of the Province.

(iii) *Inspectors-General of Civil Hospitals.*

I agree generally, but do not think that the nomination should be left to the local government.

(iv) *Executive Medical Officers, etc.*

(Higher Grade.)

I agree generally, but doubt the advisability of (b). The old uncovenanted service was tried and, I believe, not found to be a success. I can see little need, if any, for reverting to it.

(Lower Grade.)

I agree.

(Subordinate Branch.)

I agree.

45. *Indian Medical Corps Officers as civil surgeons.*—I regret that I do not understand this paragraph.

46. Indian Medical Service officers should, if possible, enter civil employ by the fifth year. I do not quite follow the rest of the paragraph.

47. It seems to me that a general list such as is indicated would involve too much transferring of officers from one province to another, with consequent increased expense to Government and to the officers themselves. I also think that it would not be satisfactory from the point of view of the civil administration.

48. I very much doubt the need or the advisability of such an Advisory Board.

49. *Civil Assistant Surgeons.*—I agree that study leave, as proposed, would be advantageous.

50. Probably this would be a move in the right direction.

51. Civil Assistant Surgeons should be made liable to military duty. I have not much faith in the effect of efforts to induce them to form part of the reserve.

52. *Military Assistant Surgeons in Civil employ.*—No remarks.

53. *Civil Sub-Assistant Surgeons.*—As far as I am aware civil sub-assistant surgeons are already liable to military duty and so form a part of the reserve. The suggestions as to study leave, free uniforms and periodical training appear to be suitable.

SCHEME D.

The designation of the proposed service "Indian Army Medical Corps" or "Indian Medical Corps," does not seem to be of much moment.

The officers should be recruited for service in India. I doubt of the advisability of admitting to the Corps seconded officers of the Royal Army Medical Corps.

As regards placing the Corps under the control of the Commander-in-Chief I think that this should only apply to those officers actually serving on military duty. While on civil duty, the officers would be under the control of the Government of India as at present. I do not think that any officer should be permanently transferred to civil employment. They should always remain liable to military duty as is the case now.

The ratio of medical officer, *viz.*, 4 per mille for British troops and 3 per mille for Indian troops may be accepted and should obviously be fixed with reference to the strength of the army in India.

I do not think that Royal Army Medical Corps officers should be appointed to permanent employment with the Indian Army, nor for civil employment.

I doubt if Army Medical Service and Royal Army Medical Corps officers should be eligible for the highest administrative grades in India. I am also not in favour of the proposed scholarships for Indians and others to enable them to proceed to the United Kingdom.

Terms of Service.

The terms of service at present not being considered satisfactory, they should be improved.

28 February 1919.]

Colonel G. J. H. BELL.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

Hospitals.

I do not think that the proposal for combined station hospitals is a practical one.

As regards the subordinate personnel it seems to be a mistake to regard the Royal Army Medical Corps *other ranks* and the sub-assistant surgeons as performing analogous duties.

Service in India for Royal Army Medical Corps personnel.

No remarks.

Consulting Physicians and Surgeons.

I doubt if such officers are really required.

Civil Medical Service.

There seems to be every reason why it should form a war reserve as it does to some extent at present.

Officer Personnel.

(a) This would mean many fewer officers of the Indian Army Medical Corps being in civil employment than there are Indian Medical Service officers at present. I do not think that Royal Army Medical Corps officers should be seconded for civil employment.

(b) and (c) I understand that these proposals refer to the civil medical service as distinct from the Indian Army Medical Corps. I am not in favour of the proposal, nor do I understand why Anglo-Indians have been excluded.

4. No remarks.

5. In spite of the military training proposed, I cannot see that anything definite is stated as to *liability* for military or war service.

6. I am not in favour of this proposal.

7. No remarks.

8. It is not stated what military rank would be held by officers in the first grade.

9. I do not see why these officers should not rise to the rank of colonel or major-general as at present.

10. I do not agree with this proposal.

11. No remarks.

General.

A college as proposed might, I think, be advantageous, but perhaps it would be better to make use of an existing civil general hospital.

Questions to be asked of service officers.

I.

1. In military service from 6-10-86 to 2-7-89.
In civil from 3-7-89 to date.

2. Causes for complaint or discontent are as follows:—

(a) The generally decreasing attractiveness and advantages of the service.

(b) Financial position much worse than it was anticipated to be at the time of entering the service.

(c) Conditions of life in India much worse. Expenses of living increased out of all proportion to any increases in emoluments.

(d) Much more work with less time for recreation.

(e) Great difficulty in obtaining leave owing, apparently, to smallness of cadre.

(f) Too much interference in details of medical administration by civil secretariat.

3. I have met with instances of friction but cannot remember details. To the best of my recollection the causes of friction were more personal, than due to conditions of service.

4. I can suggest nothing special.

5. (a) Two years as a minimum as at present.

(b) Question not quite understood. If the maximum period of service for transfer from civil to military be

intended, I do not see any good reason for fixing a maximum. I have always understood that officers transferred from civil to military were, with few exceptions, found to be efficient in fact more so than officers who had spent a prolonged period in military work—the reason being, I think, obvious, viz., that in civil employment there is much more opportunity for gaining varied general experience not only of medical work proper, but also of administration. Officers in civil employment have to act usually much more on their own initiative than is the case in military.

Questions for witnesses.

II.

1. I have not noticed any particular defects in organization. My opportunities for seeing the work of the Royal Army Medical Corps have been small.

Neither of the schemes altogether commends itself to me. Scheme A is more explicit than scheme B which is difficult to follow, diffuse and contains extraneous details which do not appear to have much immediate application to the questions under consideration.

NOTES AS TO THE TWO SCHEMES PARAGRAPH BY PARAGRAPH.

SCHEME A.

Paragraph 1 (a).—Royal Army Medical Corps only.—I do not approve of the doing away with the Indian Medical Service. The auxiliary corps for the purposes of the Indian army which it is proposed to recruit from Indians and Anglo-Indians will not, I think, be satisfactory. Apparently it will be on an inferior footing to the Royal Army Medical Corps. I do not see why Europeans should be excluded from the cadre of medical officers working with the Indian army. The term Anglo-Indian is a vague one and will present great difficulty in definition and application in practice.

(b) *Officers' recruitment, etc.*—Recruitment for the auxiliary corps cannot be the same as for the Indian Medical Service if Europeans are to be excluded. There is no such restriction at present.

(i) }
(ii) } No special remarks.
(iii) }

(c) *Terms of service.*—I can express no opinion as I do not know what terms are contemplated for the present Indian Medical Service.

(d) *Promotion.*—Terms for Royal Army Medical Corps not being available, I am unable to express an opinion.

(e) *Hospitals.*—It is difficult to understand how a combined hospital for British and Indian troops can be successfully managed.

(f) *Nursing Service.*—I have not sufficient knowledge of this subject to enable me to express an opinion.

(g) *Subordinate personnel.*—(1) Sub-assistant surgeons are qualified medical men with registrable qualifications.

(2) Royal Army Medical Corps other ranks are not qualified medical men. Generally speaking their work is, I understand, that of hospital orderlies.

Apparently it is intended that sub-assistant surgeons and Royal Army Medical Corps other ranks should perform approximately the same duties. I do not think that this will be practicable, nor desirable.

(3) *The contemplated Indian Hospital Corps.*—I do not think that it would work well to have this as a section of the Royal Army Medical Corps and the position of the sub-assistant surgeons in it requires definition.

(4) I do not understand what is meant by the expression “till the present necessity ceases.”

(h) *Pay and promotion for subordinate ranks.*—No remarks except that the present pay of sub-assistant surgeons is not likely to attract sufficient candidates for long.

28 February 1919.]

Colonel G. J. H. BELL.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

(i) *Periods of service in India for Royal Army Medical Corps personnel.*—The period of five years appears suitable. It is understood that it includes Royal Army Medical Corps *other ranks*, but not the Indian section of the Royal Army Medical Corps though this has not been stated.

(j) *Consulting Surgeons and Physicians.*—Possibly the appointment of such officers would be advantageous.

II.—The Civil Medical Service.

The establishment of such a service will mean the abolition of the present Indian Medical Service. I am not in favour of this. As regards forming a war reserve, the scheme does not apparently provide for making members of this service liable to military duty (except certain periods of training), or field service, though I presume that it is intended that they should be liable for such service. It will be necessary to state this definitely.

(a) Officer Personnel.

1. I do not think that it would be satisfactory for the civil department to have to provide for Royal Army Medical Corps officers seconded for five years, nor do I think that a proportion of 10 per cent. of the civil appointments would be of much advantage from a military point of view, though it would certainly give some officers a more varied experience than they could get in military employment. I agree that an officer should not be seconded until he has completed five years' service and has passed in the vernacular, but it is not stated in which vernacular he would have to pass.

Will officers of the auxiliary corps be eligible to be seconded? This has not been made clear.

2 and 3. Admission by direct competition is apparently to be confined to Europeans and Indians. It is not understood why Anglo-Indians have been excluded.

4. No remarks.

5. No remarks except that I think that six months' duty at a station hospital at the beginning of service and at the end of each five years would not be so useful either from the military or civil point of view as a similar period spent at a large civil general hospital.

6. I do not think that seconded officers should be placed in the first grade.

7. No remarks.

8. It is not stated what temporary military rank would be held by officers in the first grade. This should be defined.

9. No remarks.

10. I can see no reason why grades 1 and 2 should not be available for military service.

11. No remarks.

Points of the scheme.

1. There is certainly no unification, but the proposed civil medical service is an entirely new service.

2. I am unable to follow this. I cannot see how an adequate medical reserve is provided. I can see nothing in the scheme making the members of the civil medical service liable to active military service. The number of the civil medical service would not, I think, be sufficient for a reserve.

3. I doubt if there will be much, if any, advantage in compelling the personnel of the Royal Army Medical Corps to do military duty in the United Kingdom for one year after five years in India [vide (a) 1]. There seems to be no good reason why, if military hospitals in India are as well equipped as those in the United Kingdom, the personnel should not keep up a knowledge of western military arrangements. In this scheme I can see no mention of the classes of civil assistant surgeons and civil sub-assistant surgeons who have, I believe, in the late war formed a very large part of the reserve. The latter are at present liable to military duty, but not the former. Both should be made liable. There is also

the question of medical officers employed by local bodies. These are not at present liable to military duty of any kind. I think that they should be made liable. At present the number of medical employés of local funds shows a tendency to increase with a corresponding diminution of Government sub-assistant surgeons. This must have a bad effect on the reserve of sub-assistant surgeons. I can see nothing in the scheme as to the Indian Medical Department (formerly Indian Subordinate Medical Department).

SCHEME B.

1. Not much can be hoped from private practitioners unless some form of liability for military service be introduced.

2. *Ratio per mille.*—If the ratio is to be raised to 3 per mille it is obvious that a large increase in the cadre will be necessary.

3. *More officers in civil employ.*—Local governments could certainly find employment for a somewhat increased number of commissioned medical officers, but from a civil point of view it will have to be considered what effect this will have on the present policy which seems to be to gradually increase the number of appointments to be filled by civil medical officers of the assistant surgeon and sub-assistant surgeon classes.

4. *Size of the new service.*—The calculation does not appear to be correct. The figure 450 should apparently be 672 Indian Medical Service officers for military duty if the proportion be raised from 1.2 to 3 per cent.

5. *Percentage of ranks of Royal Army Medical Corps.*—I do not follow this argument.

6. *Royal Army Medical Corps volunteers.*—The suggestion as to military assistant surgeons with registrable qualifications being allowed to join the service as officers appears to be equitable.

7. *Percentage of administrative appointment.*—No remarks.

8. *The Director, Medical Services' appointment.*—I think that it would be only fair that the post of Director-General, Medical Services, as proposed in this scheme should ordinarily be held by an officer from the unified service.

9. *Pay and allowances.*—No remarks.

10. *Language examination.*—The suggestion appears to be good.

11. *Pensions.*—This would appear to be a question for an actuary.

12. *Anomaly of military promotion from civil.*—As far as I am aware the promotion from civil to the military administrative grade has not generally been unsatisfactory but often the reverse. My own impression is that officers who have had a varied experience in important civil posts are more likely to do well in a military administrative post than officers who have passed all their time in military employment.

13. *"Residuum" appointments in civil employ.*—It is not very clear what the residuum appointments are but if by this term is meant "special appointments" such as pathologists, bacteriologists, etc., I think it would be a pity that their services should be lost to the army.

14. *Rank of Surgeon-General with Government and of Inspector-General of Civil Hospitals.*—I think that it is a distinct advantage that the local administrative medical officer should be of a higher rank than any of the executive officers, i.e., he should continue to be a surgeon-general or colonel. I can see no advantage in limiting his rank to that of lieutenant-colonel as proposed.

15. *Seconded officers.*—I do not see why an officer who has not obtained an "indispensable residuum" civil post by the end of 20 years' service should no longer be eligible for any civil post. Civil surgeons will often be at their best at about 20 years' service.

16. *No Indian Civil Medical Service.*—I agree that "No Indian Civil Medical Service" is desirable. I cannot

28 February 1919.]

Colonel G. J. H. BELL.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

see that this would be of any advantage as compared with the present system. Its formation would mean a distinct loss to the army medical reserve. I doubt as to the practicability of forming a special reserve from private practitioners and assistant surgeon classes, unless liability to military service be made compulsory. I do not know if this is within the range of practical politics.

17. *Advisory Board.*—There is something to be said theoretically in favour of this. At the same time it would probably be found in practice that no better selections would be made than has been the case in the past. I do not see any reason for including a military officer in an Advisory Board dealing with promotions. As regards promotion from civil to military I am not at all sure that experienced officers from civil employment will not make better administrators than those who have passed all their time in military duty.

19. *Alterations to leave rules.*—No remarks.

20. *Medical Staff College.*—A good suggestion, but it might perhaps be found better to arrange for medical officers to be attached periodically to a large civil general hospital.

21. *Abolition of area allotment.*—I am under the impression that officers appointed since 1896 are borne on one cadre. There seems to be no good reason why the allotment of area should not be abolished.

22. *More Europeans in civil employ.*—I fail to understand this paragraph.

23. *Provision for the treatment of women and children.*—The proposal to have a European medical officer in every military station and at every district headquarters has a good deal to recommend it. It would, if given effect to, of course, very much increase the existing cadre and of necessity the cost of the maintenance of the services. I agree that the absence of suitable European medical attendants in the army and in civil districts will have a prejudicial effect upon the recruitment for all the European services in India. I have already alluded to this in my letter no. 15164 of 24th December 1917 to the Secretary to the Government of Bihar and Orissa. In view however of the present policy of Government which, it is understood, is to increase the number of Indians in Government service, it is difficult to see how the proposal can be given effect to.

24. I agree that it would be a retrograde and dangerous step to separate entirely the civil from the military medical officers in India. The question of a medical reserve for the army is, I consider, a most important point.

25. The remark as to increased expense appear to be sound. If the medical services are to be improved they will have to be paid for.

2. As I have stated under (1), neither scheme altogether commends itself to me. I cannot say if they will meet the approval of the War Office or the needs of the army in India. I have made my criticisms in detail on each scheme under question (1).

3. I doubt if either scheme would attract a good class of recruit. I can only suggest increased pay and pensions and greater opportunities for leave, but I am not at all confident that these would be effective.

4. There has, as far as I have observed, been so far no marked result. Generally I would say that the discipline of the subordinate medical services has suffered from the lack of European supervision.

5. As I do not recommend either scheme I cannot answer this question. It seems obvious that any scheme would be affected by the needs of a war on a large scale.

6. Neither scheme would, I think, give a sufficient reserve. As far as I can judge the most practicable scheme would be to make all Government medical officers and the medical officers of local funds, liable to military service; practically medical conscription.

7. I consider it to be most essential to have a medical reserve for war present in India, and this reserve would be the better for some military training.*

8. The Indian Medical Service reserve (civil side) has, I believe, been most useful in the war, but its numbers have obviously been inadequate.

9. I suggest no special system of recruitment. As stated before, compulsory liability for military medical service would appear to be necessary if a proper reserve is to be maintained.

10. The existing study leave rules are, I believe, on the whole satisfactory.

11. No remarks.

12. I cannot say how far it has declined, but my general information is that private practice is very much less than it used to be. The chief reasons for the decline appear to be—

(1) The greatly increased competition due to the large increase in the number of Indian qualified medical men.

(2) The great increase in the official work required of Indian Medical Service men in civil employment necessarily leaving them much less time for private work.

III.

Special questions.

1. In my opinion the demands alluded to are based to a great extent on the professional merits of doctors educated entirely in the United Kingdom being considered to be superior to those educated in India. This opinion is, I believe, generally, though not always, correct. It cannot be denied that the racial question is a strong factor in the case, most Europeans, especially women, preferring to be treated by a European doctor rather than by an Indian.

2. Generally the Europeans have not been fully satisfied with the treatment received from Indian substitutes though there have been exceptions. I cannot give details and only record my general impression. As far as I know the Europeans have had to put up with the medical attendance available for them.

3. I think that the efficiency of Indian medical officers of the various grades is very fair especially among those from the medical colleges, i.e., assistant surgeons. Many of the sub-assistant surgeons are also efficient. On the whole I consider that efficiency has generally improved considerably.

IV.

Medical Stores Department.

1. The authorities of medical institutions not wholly supported by Government make their own arrangements for the supply of medicines and medical stores, both in the case of annual and emergent indents. The purchases are made from private firms of druggists in India or in Europe.

2. The responsibility for indenting rests with the medical officer of the hospital or dispensary. The indents are checked and passed by the civil surgeon before the drugs are purchased.

3. I have no suggestions to make.

Note on "Questions to be asked of officers regarding assistant surgeons and sub-assistant surgeons."

1. Copies of the bonds for assistant surgeons and sub-assistant surgeons are attached.* No essential change has been made during the war. Only the name of the High Court has been changed to Patna. I think that the bond for assistant surgeons should contain a clause as to liability to military duty as a condition of appointment.

* Not printed.]

28 February 1919.]

Colonel G. J. H. BELL.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

The bond for sub-assistant surgeons already contains such a clause, but I think that it should be made more definite and of wider scope.

As far as I am aware there has been no difficulty in enforcing the conditions of the bonds as regards civil duties. Difficulty has been experienced with regard to sub-assistant surgeons deputed to military duty. It has been necessary to dismiss twelve sub-assistant surgeons for refusal to obey orders for military duty.

2. It would be possible to make the bond renewable before the expiration of the first five years. I feel convinced however that this would not be acceptable but I cannot predict if it would have any serious effect on recruitment. The period might be up to the completion of the 20th year of service.

3. The conditions of service are, I think, generally satisfactory, but the pay of both assistant surgeons and sub-assistant surgeons seems to be insufficient in view of the long courses of study which these men have to undergo. I consider that increases are called for.

4. The number of assistant surgeons and sub-assistant surgeons which could be supplied for military work without a serious dislocation of the medical and sanitary services would depend on the number of men available for temporary employment to replace them. During the war sufficient temporary men have been forthcoming in this province (but many of them from Bengal). In Bihar and Orissa out of eighty assistant surgeons thirteen or 16·2 per cent. and out of one hundred and eighty-six sub-assistant surgeons sixty-eight or 36·5 per cent. have gone to military duty.

The number could, I think, be advantageously increased. It would be necessary to create new appointments for assistant surgeons or sub-assistant surgeons or to have a large number of men on supernumerary duty. The increasing number of employes of local bodies has necessarily the effect of diminishing the number of Government men available for military duty. I can see no good reason why employes of local bodies should not be made liable to military duty. This proposal practically means a modified form of conscription of the medical profession.

There was during the war a certain amount of dislocation of the medical services by the withdrawal of men for military work but the actual difficulty and loss of efficiency was, on the whole, less than might have been expected.

5. Yes Assistant surgeons should be made liable for military duty up to 20 years' service, or possibly up to 15 years' service might be sufficient. The average

age at which assistant surgeons have joined the service during the past 5 years has been 25 years 7 months.

6. This is a very wide question. It cannot be said that the ordinary medical requirements of the general population are satisfactorily met by the present arrangements. Actual State requirements on the civil side are on the whole satisfactorily met. The only really satisfactory improvement as regards the efficient medical treatment of the people would be to have a State medical service all over the country instead of the present system by which local bodies make a large part of the provision for medical needs. I doubt, however, if such a scheme is, under present conditions, practicable.

7. I think that the military sub-assistant surgeon in an Indian station hospital should fill the position of resident medical officer and assistant resident medical officer. I presume that there would be several sub-assistant surgeons attached to each station hospital in proportion to the size.

8. I cannot say.

9. I have had no opportunity of comparing the qualifications of the two classes.

10. I should think that there is a field for the employment of both assistant surgeons and sub-assistant surgeons in military hospitals and that they could form part of a war reserve.

11. The only suggestion that I can make is that of increased pay.

12. I cannot say if the military assistant surgeon is necessary in a British station hospital. If he be displaced it seems obvious that an increase in the cadre of the Royal Army Medical Corps would be required. He could not be replaced by a non-professional trained man. His work as resident medical officer could only be done by some other class of professionally trained men.

13. (a) I have no information.

(b) Not at all as far as this province is concerned.

14. He might be employed to some extent in the civil department as at present.

15. The conditions of education seem to require some improvement, which should not be difficult to arrange for.

16. If his qualification be raised to the standard required to obtain a qualification registrable in the United Kingdom, I doubt if many candidates would be forthcoming for the military assistant surgeon service.

17. He might be employed to some extent in the civil department.

18. No.

COLONEL G. J. H. BELL, called and examined.

(President.) He did not approve of any of the schemes, and was unable to suggest one himself, as he did not know on what points his scheme would require to be based. He would like to know what were the defects in the present Indian Medical Service, that called for a reorganisation of the medical services.

He had heard of instances of friction, but the causes were more personal than the outcome of the present conditions of service.

He had been in civil service since 1889, and his military experience was small, covering a period of about 3 years.

He saw no reason why the present Indian Medical Service should not serve the civil needs of India as well as the needs of the Indian army, provided the cadre was increased and the emoluments of officers raised.

When at Home he was not in touch with the medical association, but he had met some of its members with whom he had had conversations. Those to whom he had spoken had heard for many years, and had also read in the medical journals, that the Indian Medical Service was cramped. Even if the cadre was enlarged and the rates of pay increased, he doubted whether the Indian Medical Service would prove attractive to medical men in England. There was a strong movement, on the part

of the Government of India, to increase the Indian element in the service; whereas the schemes all seemed to him to deal rather with increasing the European element. He did not see in any of the schemes the suggestion to promote Indian medical subordinate officers to civil surgeoncies, which has been a very great point with the Government. If it was intended to bring in Royal Army Medical Corps officers from England and independent European practitioners, he did not see where the Indian came in. Another point was that the schemes appeared to debar Anglo-Indians. It was suggested that recruitment should be made from Europeans and Indians, but no mention was made of Anglo-Indians. Anglo-Indians were rather necessary people to provide for. There were quite a number of Anglo-Indians in the service and some of them were very good men.

He was very much in favour of preserving the present Indian Medical Service, if it could be done, but he was afraid that the Indian Medical Service was doomed. He was very doubtful if recruits could be obtained in sufficient numbers. There was a difference between the Indian Civil Service and the Indian Medical Service in this respect, that the young men in the former service who came out to India were educated merely in a general

28 February 1919.]

Colonel G. J. H. BELL.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

sense, whereas the Indian Medical Service officer being a specialist in medicine could make his living anywhere. A doctor's income at Home at the present time was three times as much as it used to be in the days gone by, owing to the supply of doctors being so small. Only a small number of medical men from Home would be tempted to come out to India.

He saw no way of remedying the difficulty that European civil officers in India experienced with regard to obtaining European medical officers to treat their families, unless people brought out their own private physicians from Home, as was done in tea plantations.

(General Hehir.) His point was that calling the new service a corps made no difference to calling it a service, and therefore he saw no need for the change of designation. If, however, it was contemplated that the new service was to command a corps, he saw no objection to the change of designation.

He did not see why medical officers of one corps should be seconded into another. He would let things remain as they were, the Royal Army Medical Corps looking after British troops and the Indian Medical Service after Indian troops and the civil needs of India. He was not in favour of grouping them altogether and using them as best thought by the administrative authorities.

It would be very inconvenient for the civil authorities to have transfers of Indian Medical Service officers from civil to military. They might compromise with the civil in some way. It might be an advantage to military medical officers who did not get opportunities of general medical work in peace time to transfer to the civil, but it would inconvenience the civil authorities to have Indian Medical Service officers in civil employment transferring to military. He did not agree that officers who were transferred to military service after a prolonged stay in civil were unsatisfactory as administrators. They were very often officers of large experience of general administration, and he could hardly conceive that military medical administration was so technical and complicated that an Indian Medical Service officer could not pick it up in a few months. Although an administrative officer was removed from the academic part of his profession, he ought to know something about it. He could not pit his opinion against that of the Adjutant-General or the Commander-in-Chief, who were of opinion that Indian Medical Service officers were not as capable administrative officers as they ought to be; but his impression was that a really good civil surgeon, who had had charge of a large district or hospital or jail, was better prepared to take up administrative work than an officer whose experience had been confined to a station hospital.

He saw no objection to the establishment of a medical college in India, provided that the civil hospital in the station where the staff college was situated was affiliated to it.

He agreed that inter-relationship between the civil and military services should be maintained. It existed to a very great extent now.

The figure 450, in connection with the size of the new service, appeared to be a mathematical error, and should be 672, if the proportion was to be raised from 1.2 to 3 per cent.

He saw no objection to the promotion examination for lieutenant-colonels, if it was to be an examination in administration and organisation only and not an academic one.

He doubted if it would be feasible to gather together all branches of the rank and file of the reserve once a year, for military training, as the expense would be enormous. He was looking at it entirely from the financial point of view.

If military assistant surgeons were abolished, he did not see whom they could get to take their place. The rank and file of the Royal Army Medical Corps were not qualified men and could hardly be considered suitable substitutes. He thought that junior officers of the Royal Army Medical Corps would be required to take the place of the present military assistant surgeon, if the latter were abolished.

He would favour the suggestion to increase the standard of medical education of the military assistant surgeon class. If, however, his qualification was raised to that of a qualification registrable in the United Kingdom, he did not think many candidates would be forthcoming for the military assistant surgeon service. Some of them were very able men, and he did not think they would work as ward masters in station hospitals if they were better qualified.

It was absolutely necessary to fix a limit to the number of Indians entering the Indian Medical Service, not only from the military point of view but also from the civil. There was a great deal of dissatisfaction among civil officers on account of the prospect of having none but Indian doctors to treat them. If they were going to have a large number in the whole service, the proportion in civil would go up. Some civil officers had the idea that they were unfairly treated, and were entitled to the services of European medical officers.

He did not favour simultaneous examinations in England and in India.

He advocated making military duty compulsory for civil assistant surgeons and sub-assistant surgeons.

Military Indian Medical Service officers coming into civil were better than purely civil medical officers, because of the military training they had received. They were accustomed to discipline and better able to carry out orders.

The reduction of Indian Medical Service officers in the Bihar and Orissa province would decidedly hamper the development of medical work in the province.

(Major Cramer Roberts.) If a Royal Army Medical Corps officer was liable to have Indian troops placed under his care, it was obvious that he should have had previous experience of such troops.

(General Hendley.) He had no suggestion to offer with regard to the difficulty of filling administrative appointments on the civil side, if officers had to elect, at the end of 20 years' service, for the military. If officers were not allowed to take up administrative posts on the military side, there would be a diminution in the number of administrative appointments for officers in civil employ, unless they increased the number of posts on the civil side. Some of the provinces were rather big and there was a tendency to partition them.

(General Giffard.) If a big reserve of assistant surgeons and sub-assistant surgeons was needed, you must expand the civil side of the service.

He had had trouble with his civil sub-assistant surgeons in regard to military service. They had bonds providing for military duty, but it was found difficult to get them to adhere to the terms of the bond in that respect. He had found it necessary to dismiss twelve sub-assistant surgeons for refusal to obey orders for military duty. He did not see how this difficulty was to be got over. His Government would not agree to their being employed as military sub-assistant surgeons, and he did not think recruits would be obtained for such a service. People in Bihar and Orissa had strong objections to military duty. Those who had signed bonds signed them in the belief that the possibility of active service was very remote.

He favoured the idea of having special appointments as consultants, carrying extra pension and more pay, for officers of the Indian Medical Service in civil employ, who possessed high professional qualifications, without necessitating their return to the army.

(President.) Most of the civil surgeons in the province of Bihar and Orissa were at present Indians. There were 3 who were not Indians, who were employed at Ranchi, Puri and Cuttack. Civil officers, though not complaining officially, had expressed themselves as dissatisfied with medical attendance at the hands of Indian medical officers. For ordinary ailments European civil officers employed Indian doctors for their families; but, for confinements and serious disorders, they invariably sent their families to Calcutta or Ranchi. This would be the only solution of the difficulty in future.

28 February 1919.]

Lieutenant-Colonel C. E. SUNDER.

(The schemes and questions referred to by witnesses are contained in Volume III.)

LIEUTENANT-COLONEL C. E. SUNDER, I.M.S., Civil Surgeon, Patna.

*Written statement.**Answers to questions for witnesses.*

1. The only test of an organization is the way in which it works, whether it accomplishes that for which it is created. From the military point of view I take the essential objects of organization to be—

- (a) To maintain troops in health (sanitation).
- (b) To treat them efficiently in disease and injury.
- (c) To be prepared for the incidence of war at any moment.

Any military medical organization which fails in one of these respects stands condemned. My experience of military medical organization is limited to what I saw at Netley, to what I saw during over five years, at Mean Mir, at Peshawar, with the Punjab Frontier Force, and during the Sikkim and Miranzai expeditions. My later experience has only been what I have seen of military medical officers. On the efficiency of these officers the attainment of the above three objects ultimately depends. From my limited experience the radical defect in military medical organization is its effect upon its medical officers, whom it tends to alienate from their profession of medicine and surgery. The average medical officer of over 10 years' standing in military has seemed to me better at the drilling of a bearer company or the management of a hospital in strict accordance with military rules than at the treatment of disease, quicker in appreciating the alignment of beds than at recognizing grave symptoms and signs, better with a swagger stick than with a scalpel. These men must have started well. If my impression of what ten years' military duty had done to them be even approximately true then there was and still is something radically wrong in the organization that makes such results possible. It was suggested to me that military medical officers are so overlaid with routine duties not directly connected with medicine or surgery, have so much clerical work to supervise in connection with their charges, are subjected to so many transfers, that their energy is spent and very little left over for medical and surgical study. I am also told that it is necessary to call in a "specialist" before any grave operation is undertaken, and I know that this was done in one case with fatal delay, was not done in another case of medico-surgical urgency where the medical officer had the courage to do at once what seemed best. There seems to be something radically wrong in an organization which even tends to produce medical and surgical inefficiency. It will not be cured by quinquennial bursts of study. A medical officer must be enabled continuously to grapple the new whose adoption has been tried, to slough off the old and effete in medicine and surgery.

The blood of West and East has just been shed to crush the spirit of unjust aggression and lay the foundations of a Great Peace. All four schemes aim at creating an enlarged medical organization fit to meet the exigencies of "War on a large scale." Can such activity in India be thought consistent with the earnestness with which some of the finest intellects in the West are striving to elaborate a means whereby outbreaks of human savagery shall be controlled?

All four schemes have a strong military bias; not one of them considers whether economic conditions in India can bear the strain of the costly expansion it proposes, and in none of them are the needs of the civil medical service or the civil population given adequate consideration.

None of these schemes commends itself to me in its entirety. If one must choose I prefer C, with considerable alteration in detail, because it is the necessary half way house to the development of an Indian Medical Service which shall minister to the needs of all troops in India. I conceive it to be better for the health and

treatment of British troops that they should in India be in the hands of British officers who have acquired their major experience in India, and it seems to me feasible that the military organization of this Indian Medical Service should, *mutatis mutandis*, be the same as that of the Royal Army Medical Corps. They would very rarely have to serve in the field with this Corps and, with a parallel organization, no disjointedness should arise when they do happen to meet in the field. I object to the designation "Corps" for its purely military connotation. The expanded Indian Medical Service must remain the ordinary avenue to civil employment if we want an economical reserve for war. If 4 per thousand be needed for British troops I find it hard to believe that fewer medical officers are needed for the care of Indian troops—Equalize the ratio, or uniformly reduce it in this expanded Indian Medical Service, in which probably a smaller ratio per thousand will be needed, since a war reserve in civil employment must be maintained and might advantageously be increased. That reserve is economical and the officers in it are a better reserve for having had about 5 years of intimate military experience.

Therefore I see no impropriety in their having used the army as an approach to where there is wider scope for medical and surgical experience. I maintain on the one hand that this reserve of officers should be dislocated as little as possible, and on the other that it should be utilized even under ordinary conditions by the army. The civil surgeon of every large station is in my opinion the appropriate consultant in surgical and medical cases. His experience in a wider practice than befalls most men should be made available when needed instead of multiplying the number of so-called specialists, a title obtained at least sometimes in the army on a very meagre basis of experience.

If such a plan were adopted the utility of officers deemed to be "permanently lost to the Army" would be considerably increased. It should be recognized that the bent of these men is not towards "routine military work" but towards pure medical and surgical practice, and I venture to assert that they might in base hospitals and elsewhere be advantageously employed, in war, in the exercise of their purely medical and surgical talents. The suggestion that civil surgeons should after five years' experience be continuously transferred to military duty seems to me no less than exploiting the civil medical service and the civil population for the benefit of the army, a position which the civil authorities would not tolerate.

I should like to comment upon paragraphs 49, 50, 51, 52, 63, 64, 65, 78 but it is impossible to further expand this written answer in the time at my disposal.

2. I see no reason why the scheme C, modified, should be unacceptable to the War Office or fail to meet more effectually the needs of the army in India. I have already criticised it in parts.

3. The modified scheme would I think attract a better class of recruits, provided it be recognized as a scheme for a combined military and civil service, the former being the avenue to the latter and the latter a reserve for the former in war, with the minimum of dislocation in peace and war.

It would I think be fatal now to treat the army as more important than the civil side of medical work in India. Remove the possibility of civil employment after a period in military, or make civil employment only an interlude, and less attractive, and I am convinced the quality of your recruit will fall as it has done.

4. With regard to the charge of troops I can say nothing. Civil districts have had the services of the best of the assistant surgeons to whom military duty, on the terms offered, was unacceptable. The work of

28 February 1919.]

Lieutenant-Colonel C. E. SUNDER.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

the assistant surgeons acting as civil surgeons was less efficiently done by junior and temporary assistant surgeons. On the whole district work was done well, I believe, but a great strain was put upon the few Indian Medical Service officers who remained. I believe some of the jails fell off in discipline, in management, and in health.

5. In its unmodified form it will not meet the needs of the civil administration which will not and should not tolerate being continuously exploited for the army.

It would I think be equal to the needs of any ordinary war on a large scale, and no scheme need be formulated for war on the large scale of the last war.

6. In all ordinary wars a reserve would be adequately provided for in an expanded Indian Medical Service and the entire reserve need not always be present in India. A civilian reserve seems to me unnecessary.

7. A trained reserve seems obviously necessary but the whole of it need not be present in India.

8. Only an officer from the areas of war can answer this. From what I have heard, the Indian Medical Service reserve (civil) was not put to the best use the nature of its experiences called for, and any estimate of its value under those conditions must necessarily be false.

9. I accept the suggestions of scheme C as to recruitment, but am sceptical of the need of an Indian Millbank unless a large hospital for tropical disease be annexed, and that is impossible except in great centres where such hospitals already exist and can be utilized as fields for post-graduate study.

Continuous self education would be greatly helped by the provision of kept-up-to-date medical libraries at every station hospital. I can hardly believe that the routine, ultra medical and surgical, work of the military surgeon has become so complex as to call for a College for the education of officers who have been through Millbank. It may be needed for those branches recruited in this country. Purely professional, *i.e.*, medical and surgical and kindred, education would I am persuaded be better in post-graduate classes in India and in England and America.

10. Post-graduate study should be compulsory and facilities given for it as well as warrants obtained that the leave granted has been used correctly, but it seems to me absurd to demand that senior men shall pass examinations. They should have eyes and ears open at great clinics and be able to detail how they have profited, say, in a report.

11. Facilities for research should exist in every station hospital and more detailed research encouraged by providing for accommodation and direction in the several great laboratories that already exist in India and England. A special department seems to me unnecessary. It is the appreciation of what may come of research that was lacking. The failure of sympathetic treatment did harm, driving such men as Ross out of the service. Let the balance not swing too far in the opposite direction.

12. I know two civil stations well. In them private practice has declined to the extent of about 75 per cent., if my information of the past be correct. The reasons seem to be—

- (a) Greater facilities for travel and more frequent resort to Calcutta by rich folk.
- (b) Gross abuse of hospitals by those who can well afford to pay but prefer to simulate poverty.
- (c) The unwise interference of government in questions of fees, which has discredited its officers, by imputing evil, and encouraged the public to underrate them and exploit them.
- (d) The establishment of some so-called paying wards and hospitals often resorted to by those who can pay and sometimes wish to pay for attendance, but may not. Some of these institutions are an injustice to the government officer and to the private practitioner. But for British prejudice much might be learned from America as to the working of paying wards as I saw them there.

- (e) An enormous improvement in education of the Indian practitioner so that the civil surgeon mostly sees cases now only in consultation with him. One must make himself "*persona grata*" in order to be consulted often.

Answers to questions asked of service officers.

1. I was about 5½ years in military service and have been about 25 years in civil service.

2. Yes—I have had cause for complaint and discontent. I frankly entered the service in the hope of passing into the civil side. I know I did well in military and I hoped to enter civil in accordance with my position on the roster of applicants. That roster has been too often overridden by the exercise of influence. I will not go into details or give names but I know that influence has often weighted the balance in the making of appointments, sometimes, though rarely, in favour of men of small professional ability who have been 'boosted.'

This is one of the grievances never mentioned except among ourselves which has disheartened us.

I expected to be able to keep out of debt and found that my pay and earnings for the first 12 years just enabled me to get out of debt and I have not been extravagant. I expected to be able to work at medicine and surgery and to continue some of the research work begun under Professors Schaefer and Halliburton but found this impossible in military service. I sought civil employ because I wished not to lapse into the state of some of the men I had seen, also because I hoped to earn more. I found in civil that my pay was actually less by 100 than I received for substantive charge of the 5th Punjab Infantry. I thought that the leave rules were reasonable, but in 30 years I have been able to go on furlough twice and have had uncombined privilege leave for four months, sick leave never. When I retire I and my family will have very little more to live on than what is left of my pension after the deduction of income tax. I have saved just about enough to pay the premia on my life assurances.

3. I have met with no cases of friction with the Royal Army Medical Corps.

4. I would make the *pay*—not the salary (this is a distinction apparently not appreciated in the schemes) a living wage. That 33 per cent. rise, which I am told has been sanctioned, will not be enough. The cost of living all over India has risen by about 50 per cent. if I may judge by my own experience. I would make it compulsory and make it possible for men to go on leave for not less than six months after every five years. The wisdom of this is recognized by business men. I would afford facilities for study during military employment in India, and would make study a duty periodically in the great hospitals in India, especially during a man's early career.

If medical men serving in India are all in one service friction and some grievances will be reduced to a minimum. Some grievances will be removed if appointments are always justly made. I do not think any Advisory Board can possibly judge a man better than his immediate superior, given that this officer eliminates prejudice and personal inclination of outside influence from warping his judgment.

Other grievances would be removed if all appointments on the military side were given only to officers on that side; all civil appointments only to men in civil employ. Scheme C claims some civil appointments for any officer of the whole service, and denies any military appointment to every officer in civil. This is unjust in my opinion. The higher civil appointments just as much as the higher military require special experience and knowledge.

5. I consider that—

- (a) An officer should not ordinarily be transferred from military to civil employment after 7 years in military. Such transfers should be very exceptional after the 7th year and never

28 February 1919.]

Lieutenant-Colonel C. E. SUNDER.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

after the 10th year. Men tend to take a permanent set with the conditions they serve under. To unbend them is bad economy.

- (b) There should ordinarily be no transfers from civil to military after the 15th year of service and as far as possible after five continuous years of civil employment. The reason is the same, and added to it is the grievous dislocation and injury to civil work. With a larger reserve of military medical officers *plus* those in civil who have no more than 5 years' civil service, the military machine should be more than equal to all emergencies other than the like of what we have just seen and I expect are unlikely to see again.

Medical Stores Department.

1. By purchase in the open market.
2. Managing Committees draw up indents under the advice of the medical officers. These are checked by civil surgeons and returned for consideration by the Committee. They come back to the civil surgeon who places the order with an accredited firm.

Indents for State hospitals are checked in the civil surgeon's office, bulked together and submitted to the Inspector-General of Civil Hospitals, Bihar and Orissa, who sends them to the Medical Stores Department. In recent years there has been an enormous waste of printed paper on the voluminous forms which have been introduced.

It would not be a convenience to use as sole source of supply the Medical Store Depots, which are autocratic institutions, slow in action and never admitting any errors.

An attempt was made to buy in bulk from one British firm. It proved so unsatisfactory that I should be loath to see it tried again. There was some saving in cost, little improvement in quality, and much annoyance from mistakes. Increased manufacture in India should be encouraged.

3. I have no knowledge of the inner working of a Medical Store Depot, only of friction with it on the receipt of each supply.

Special questions.

1. Europeans in the public services still display a marked predilection for medical officers of their own race, but there has I think been a decrease of this except in certain flagrant cases of race prejudice, and under certain conditions. There has been so much improvement in the education of assistant surgeons, generally speaking, that several of them have become acceptable for their capacity if not always for their ways.

2. Europeans during the war have been content not to complain but have not always been satisfied. In these circumstances they came to or sent for the nearest Indian Medical Service officer or put themselves to the expense of going to Calcutta from this province.

3. I have no experience of Indian Indian Medical Service officers of the higher grade except two Indian Indian Medical Service men whom I considered failures.

Assistant surgeons as a whole have considerably improved. Some of them are very capable professionally. With some exceptions the majority are defective in managing capacity. "*Surviler in modo*" they usually are. "*Fortiter in re*" they find it hard to be. They fail generally in maintaining discipline. "Give peace in my time, O Lord" is the prayer that affects their activity almost throughout, but on the whole I think they have improved in efficiency and are inadequately paid.

Of sub-assistant surgeons I would say the same. This much neglected class would be vastly improved if more consideration were given them. The best men in our Indian schools are now averse to Government

service either as assistant surgeons or sub-assistant surgeons.

The great war has put a slur on assistant surgeons (*vide* scheme C) and I wish emphatically to state that the conditions for temporary commissions were not such as could enable capable assistant surgeons to accept them. Men at a loose end came in as temporary assistant surgeons. These and those permanent assistant surgeons who could profit by a lieutenant's commission are for the most part the men who put on a brave face and volunteered to gain their bit.

The "damning with faint praise" accorded to assistant surgeons as a class seems to me undeserved by them as a body. The better men remained and had to remain in the civil department whose work could not otherwise have been carried on.

Questions regarding Assistant surgeons and sub-assistant surgeons.

1. On binding sub-assistant surgeons to be available for military service for five years only.

No alteration has been made as far as I know, and I think none is needed. For the war the enforcement of the conditions has been resisted and evaded as far as possible and as much as possible.

2. I do not think it could be made renewable. Sub-assistant surgeons would resist more as they grow older.

3. I do not consider the conditions of service satisfactory for civil sub-assistant surgeons. Their education has been greatly improved. They now obtain registrable diplomas. The best of them avoid Government service. The district boards and others are offering them better pay and prospects than Government does and they are less liable to transfers in other employment. Increase the pay and you will get the better men.

4. The province employed barely enough assistant surgeons and sub-assistant surgeons for its work. The number could not be advantageously increased because the district boards are now refusing to employ Government officers liable to be shunted about. There was considerable dislocation during the war. The Medical School at Patna suffered from frequent removal of men whose places could not be filled efficiently. Some of these men came back on leave once or twice in the first year and more than one told me he and others had next to nothing to do and were therefore allowed to go on leave.

5. Assistant surgeons might possibly be bonded to do military service during their first five years. The majority would I think be unwilling to bind themselves for a longer period.

6. The ordinary requirements of the population are fairly met in Patna and Gaya, which districts I know, but more assistant surgeons are needed as considerable dissatisfaction has arisen when assistant surgeons have unavoidably been replaced by sub-assistant surgeons. I am strongly of opinion that in matters of discipline and in professional matters all medical officers, either Government officers or officers of institutions under Government supervision, should be under the control of the civil surgeon and the Inspector-General of Civil Hospitals. District boards and municipalities are lax in discipline.

7. I cannot answer the first part of this question. I do not think the average sub-assistant surgeons equal to what should be expected of a resident medical officer of a station hospital. This is an assistant surgeon's job.

8. I do not know how a military sub-assistant surgeon is now trained.

9. I cannot answer this question.

10. Civil assistant surgeons and sub-assistant surgeons might well be employed for medical and surgical work in

28 February 1919.]

Lieutenant-Colonel C. E. SUNDER.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

station hospitals and would thereby become a better reserve for war.

11. I would increase their pay, better their prospects and minimise their transfers.

12. I cannot answer this question.

13. Or this.

14. I can suggest no field for the military assistant surgeon until he holds a registrable qualification. His present position in this respect is deplorable.

15. I do.

16. I do.

17. I would employ him as at present.

18. No.

LIEUTENANT-COLONEL C. E. SUNDER, called and examined.

(*President.*) He would favour scheme C as a half-way house. But he would prefer that the Indian Medical Service should be employed for all troops and civil duties in India. The military service should be an avenue to the civil, which should be utilised as a reserve for the former. The reserve should not be utilised so as to dislocate civil medical work to so great an extent as had been done recently. He would conceive it to be better for the health and treatment of British troops that they should in India be under the charge of British officers who have acquired the greater part of their experience in India.

He considered it fatal now to treat the army as more important than the civil side, as his knowledge of schools in England had been that men simply join the service in the hope of getting into civil. If the possibility of civil employment were removed after a period in military, or if civil employment was made only an interlude, he was convinced that the quality of the recruits forthcoming would fall off.

With regard to the decline in private practice, witness stated that one of the reasons for this was the unwise interference of Government in the question of fees. This interference had thrown discredit on the Indian Medical Service. The public were of opinion that officers of the service were grasping where their fees were concerned. The independent medical profession had enormously increased. This had been due to the number of medical schools that were in existence.

With regard to the question of leave, this was impossible within the last few years, and moreover he could not afford it.

He did not think the recent increase of 33 per cent. was in the pay of Indian Medical Service officers sufficient, as the cost of living in India had risen by 50 per cent.

On the whole assistant surgeons had improved in efficiency but they were inadequately paid.

(*General Cree.*) He had no experience of the Royal Army Medical Corps at all. He knew nothing about their organization.

(*General Hahir.*) He did not advocate the periodical return of officers from civil to military as he thought this was exploiting the civil for the benefit of the army. The senior men in civil should not be removed. The *ante-bellum* provisions for war would be quite sufficient for any future ordinary war and there was no necessity for vastly increasing them.

He thought that the ratio of medical officers should be 4 per mille for British troops and 3 per mille for Indian troops.

He did not agree with the suggestion that officers in civil employ should be transferred to military after every five years. This would do the civil side a great deal of harm and the civil authorities would not tolerate it.

He did not favour the establishment of a military medical staff college in India, unless a large hospital for tropical diseases was attached to it.

(*General Hendley.*) He advocated the grant of free passages to officers contemplating furlough.

The reason why a great many Indian Medical Service officers in civil employ forfeit their furlough was that they were afraid of not getting back their old appointments. They may have a claim to their old appointments but there was no certainty of their getting them back.

(*General Giffard.*) He favoured the idea of combined civil and military hospitals which would prevent the dislocation of military work, were it decided that the civil needs of the country were to be met by an entirely military service.

He would bind assistant surgeons and sub-assistant surgeons to military duty for the first five years. To enable this to be done it would be necessary to have a larger cadre of military sub-assistant surgeons in civil.

The best men who now pass out of Indian schools are very averse to going into Government service. District boards and business firms pay very much better and accordingly they attract the best men.

LIEUTENANT-COLONEL C. E. SUNDER, I.M.S., Civil Surgeon, Patna.

Supplementary written statement.

In my previous evidence I attempted to convince the Commission that a scheme for reorganization of the Indian Medical Service must include bolder measures for ensuring that the army medical officer shall keep abreast of the times. I was aware that in the last fifteen years encouragement had been given and facilities for study had been created, but the result seemed to me inadequate to the need. It is true that my recent experiences were chiefly in a "back-water," but I only assumed that the thirty or more men I had met in the last decade were average results of the changes in organization. Indeed, the insistent demand for more "specialists," in the four schemes submitted for criticism, seemed to imply that the professional weakness of the average military medical officers of executive rank, who form the bulk of the services, had been recognized. My belief is that, if the Indian Medical Service were again attractive enough to draw some of the best men from British schools, and the conditions of service made it possible, every average man might in due course become at least the post-graduate student now "camouflaged" under the title of specialist.

I had no experience of the working of the later organization in detail, but it had been suggested to me by one now buried in France that the average military medical officer was what the organization made him. One must allow that every army medical officer should be familiar with the details of what the organization may require of him at any moment, but need one admit that a large portion of every working day should go to the execution of details outside of his profession? I imagined not, and was ready to suggest that most of these details, might be relegated to a steward or quartermaster under control of the medical officer, as I believed was the case in the United States before the great war and probably during the war, when that army had ceased to be a negligible quantity. I held back the suggestion because I learned that the plan was in force in the French army and had proved a grievous failure. May not this have been due to the employment of men without sufficient technical knowledge of the medical and surgical requirements of an army? I think I see here a field in which some of the military assistant surgeon class might distinguish themselves. But, however this may be, I submit

28 February 1919.]

Lieutenant-Colonel C. E. SUNDER.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

there is a case for mending an organization under which only the superman grasps all the working details while still assimilating the advances in his profession; under which the man with a modicum of medical knowledge and the talents of a storekeeper may rise to command yet have so little sense of values as to rate the keen professional man for the loss of a shirt, when he is straining to account for lives; under which the average man finds it necessary to compound with his profession in order to meet the exigencies of his organization. I respectfully urge some simplification or diversion of the duties of the military medical officer in order that greater progress be possible in medical and surgical efficiency, which are his "raison d'être." If our medical organization is necessarily complex, the advances in our profession are still more complex and our scheme for reorganization must enable the average man to keep in touch with them throughout his career.

With this end partly in view I suggested that more use should be made by the army of the medical officers "permanently lost" to it, whose experience and the resources of their civil hospitals should be made available for the soldier in times of peace, as was in fact done during the recent war. It took a bolder mind than mine to conceive the idea of combining civil and military hospitals, as was suggested in the course of my examination. The more I consider the better pleased am I with this suggestion that the "dead hand of tradition" be shaken off, the divorce between civil and military hospitals be annulled where possible. You cannot effect the change everywhere; station hospitals must remain in some places, but wherever a large civil hospital is closed to a cantonment I can think of no substantial reason why military wards should not form part of a civil hospital. There cannot be two kings of Brentford, and so these wards must be under the control of the civil staff with whom military officers would be associated. With one medical service for all India, association becomes easy, conjoint labour is smoothened. With one hospital, initial outlay is halved, recurrent charges are lessened, and, in the aggregate, enormous economy is effected both of money and of men. Look at what it means financially to attach, let us say 100 medical officers annually all over India, to the greater civil hospitals for duty instead of study leave. Look at what it will mean to the men themselves to have garnered experience, as associates and co-workers in a larger sphere, against the day when they are isolated in back-waters or are called upon to show their metal in the field. There may be difficulties that I do not see, but are they unsurmountable? The advantages of combination appeal to me strongly, and they would not be to the army alone whose officers may well be imagined to give generously of their labour in a field where the workers are few. To elaborate the details of such a scheme and press its consideration is the work of more experienced hands.

In my written evidence I passed lightly over certain paragraphs of scheme C which I shall now comment on.

Paragraph 49.—"The army in India is in need of a larger staff of specialists (and consultants) than now exists." I have already questioned the appropriateness of the term specialist as now applied and have suggested the probability that under happier conditions the army will certainly contain a greater number of these progressive students of their profession. By no scheme of reorganization can the enlarged Indian Medical Service I imagine possible leap suddenly into completeness. We cannot attract to or retain in our ranks the genuine specialist of established repute, who comes to us only as a peripatetic cold season consultant in specific problems. Shall we do wisely in importing from home into a special cadre on special terms the half-baked hangers on to great hospitals who despair of reaching the higher ranks and are less adaptable to new conditions of work? Or shall we aim at being self-contained? The Indian Medical Service even in its decadence, almost despite its organization, has produced men who hold their own in their special branches and even lay down the law to the world. Reorganization aims at reviving the fame of the service, at drawing to it once more some

of the best from British schools, many of them men with the ability but not the means to wait for preferment at Home, the young equals of such as you could import. Let them be discovered early, encouraged, given facilities for specialism, and your new organization will become self-contained. Your imported neurologist will be lost where neither ward nor hospital for his speciality exists. Your sanitarian with only British experience will often be at fault. We shall do better to develop our own resources as to material and men by promoting specialism within our ranks instead of retarding its progress by the introduction of men whose presence must necessarily impede advancement. Create a special cadre by all means but let it be filled slowly by our own men, gaining experience in our general hospitals until special hospitals are provided, for ear and throat, and nose and skin and genito-urinary diseases, long before the neurologist is installed to make brilliant diagnoses with almost mathematical precision but accomplish little by treatment. Above all let us provide that men be kept to their specialties, and in particular that the sanitary department be no longer used as a vaulting horse. Let men enter it who have their hearts in the work and let the department be worth staying in.

Paragraph 50.—A college is demanded by all four schemes. This would be no staff college, such as that at Quetta, for selected officers. Its object is to train in all their duties in peace and in war the entire medical personnel of the army and of the reserve. Since our military medical organization is complex training is necessary, but, however one looks at it, the magnitude of the proposition is appalling. If the cadre of the service be raised and the reserve increased, as has been proposed, you must in this climate, in order to accommodate rank and file as well as followers, build not a camp but a city. Add to this the cost of college and laboratories and equipment, and the initial outlay will be colossal, the recurrent charges enormous. Can they be borne? Will they be borne? Need men be moved from all India to one centre for training?

I leave it at that, so far as training in the work of a complex medical organisation is concerned, but I again venture to point out that in the scheme for combined military and civil hospitals previously envisaged—located let us say at Bombay, Lahore, Delhi, Agra, Lucknow, Cawnpore, Allahabad, Benares, Calcutta, Madras and other large cities, especially where schools already exist—we have a simpler, more economical, and in my opinion more efficient means for the medical training of our officers, who would in such places be in larger fields for experience and in touch with laboratories where research is progressing. Whether here also the working principles of our organization might not likewise be studied in theory and in practice in smaller bodies is for others to determine.

Paragraphs 51 and 52.—In the course of my examination and in other connections I remarked on the injustice involved in judging the whole body of civil assistant surgeons by the civil failures and temporary men who applied for and were inadvisedly given commissions. I need not enlarge on this point, but I desire to respectfully protest against the suggestion that "the outlet into the civil medical service might be especially enlarged" for Indians who have qualified at Home but have on the military side proved less efficient, than their British confreres, or, having risen in rank, are deemed unfit for the charge of important posts. The proposal to void into the civil side what is considered unfit for the military is pernicious, a striking example of the bias of which I accused all four schemes. The civil side of our service, in which men are inevitably isolated in large districts, demands qualities in its officers such as are not likely to be found in the misfits and the "not-good-enoughs" of the military side. This sort are common enough in all government services. Judicious selection after examinations, but before the results are published, would eliminate some, both British and Indian, and others, recognized later, might well be dealt with as they would be in business life. Granting a gratuity would be cheaper than retaining them.

28 February 1919.]

Lieutenant-Colonel C. E. SUNDER.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

Paragraph 63.—If men have values it is difficult to see the logic of grading them only by seniority, of awarding the slacker or the less capable man the same pay that you do the efficient worker posted to a civil surgeoncy with more onerous duties. Places as well as men have values. If the grading of civil surgeons be invidious then at least you must grade districts.

I am unable to appreciate the reasonableness of this paragraph or of

Paragraph 64.—Which proposes that, because local governments desire to get officers at an early period in their service, the normal term of service in civil should be five years, or, in other words that officers should rotate out continuously, the young and inexperienced taking their places. I imagine that local governments are also anxious to retain those who have grown efficient in their service and familiar with their organization.

Paragraph 65.—Unless the first sentence of this paragraph be entirely governed by the motive indicated in the second the practice it aims at making general is undesirable. That a medical officer with special fitness for a particular appointment should be available for transfer to another province, where a suitable officer cannot be found, is a sound proposition. That all officers of the superior grade in the civil medical department should be liable to be uprooted from the environment in which they have developed seems altogether unwise.

Note on the working of paying wards in America.

Our British hospitals originated some from monastic beneficence, some from charitable endowments. We have no State hospitals other than workhouses, and all our institutions are struggling for existence on dwindling incomes eked out by voluntary subscriptions. The problem is how to maintain, how to improve them. The original beneficiaries were the poor and we have inherited the tradition that only the poor shall have the benefit of our hospitals, have acquired the obsession that no man shall pay in our hospitals.

The rich man can command what he needs; the man of moderate means resorts to nursing homes in the purlieu of Harley Street where he pays surgeon or physician and is mulcted heavily by the keepers of

those dismal homes; the man of little means must forfeit his self-respect by entering a hospital without payment.

In London, as far as I know, there is no paying ward in any hospital. In Boston, New York, Philadelphia, Baltimore, and other American cities, public hospitals cater for all classes. Even the wealthy can in these hospitals have suites of rooms with most of the appurtenances they are accustomed to and all the privacy they can desire.

Who can doubt that a hospital with every convenience, every necessary appliance on the spot, with nurses and skilled hands ready for every emergency, is better than any nursing home?

America has educated its public to the supreme advantages of treatment in a hospital, has kindled the interest of its rich men, has warmed their hearts and inclined their hands to charity by the benefits they have derived from hospitals, and has thus partly solved the pressing problem of their maintenance and improvement. We lag behind, making our hospital more hideous by the falsehood on its walls. "Supported by Voluntary Contributions."

But you cannot establish paying wards for all classes and yet ask men to give of their best gratuitously to all classes. It is your hospital staff who will urge their patients to resort to these wards and you must yield them the discretion to demand of their patients what they themselves deem suitable remuneration for their work.

We have imported our tradition into India and we are governed by our obsession in a country where deception comes easy and hospital abuse is gross. The niggardly rich have abused state institutions and we offer as corrective cottage wards which yield perhaps enough to maintain the buildings. Is there any excuse for the palatial paying ward in Calcutta, to which the employés of merchant princes resort, if men of business do not wholly maintain it? Examples need not be multiplied, and I close this note by reaffirming that British prejudice has much to learn from American practice regarding the creation and management of paying wards which shall pay their own way, help to maintain wards for the poor, and raise no conflict with the lawful interests of the staff on whose efforts their success depends.

3 March 1919.]

Lieutenant-Colonel W. D. HAYWARD.

*(The schemes and questions referred to by witnesses are contained in Volume III.)***At Calcutta, Monday, 3rd March 1919.****PRESENT:**

THE HON'BLE SIR VERNEY LOVETT, K.C.S.I., I.C.S. (President).

MAJOR-GENERAL G. CREE, C.B., C.M.G., A.M.S.

MAJOR-GENERAL P. HEHIR, C.B., C.M.G., C.I.E., I.M.S.

MAJOR-GENERAL H. HENDLEY, K.H.S., I.M.S.

THE HON'BLE MAJOR-GENERAL G. G. GIFFARD, C.S.I., I.M.S.

S. R. HIGNELL, ESQ., C.I.E., I.C.S.

LIEUTENANT-COLONEL A. SHAIRP, C.M.G., Indian Army.

MAJOR M. T. CRAMER-ROBERTS, D.S.O., Indian Army.

and, as a co-opted member, LIEUTENANT-COLONEL H. ROSS, I.M.S.

MAJOR A. A. MCNEIGHT, I.M.S. (Secretary).

LIEUTENANT-COLONEL W. D. HAYWARD, I.M.S., Medical Storekeeper to Government, Calcutta, called and examined.

(General Giffard.) The establishment of the dépôt was insufficient for the work required. The class of men employed were inferior, and the pay was inadequate. He had made some suggestions for the improvement of the establishment when he was at Madras, and believed that some of the increase in the establishment there had already been brought in. The present establishment is not sufficiently educated for the work it had to do. He had no Indian Medical Service officer to assist him. His right hand man was a senior assistant surgeon whose pay and allowances amounted to Rs. 500.

The reason why good men could not be obtained as clerks and compounders was that the pay offered was very low and the prospects of advancement were poor. The starting pay was only Rs. 15 or Rs. 20. Promotion was slow and after some years the most they could get would be about Rs. 50. When a good man was obtained he only remained for a short time and then left as soon as he obtained a better appointment elsewhere. He could not bring in men on any but the lowest rate of pay as otherwise they would supersede those already employed and block their promotion. It was thus impossible to obtain men with a satisfactory education.

He was not satisfied with the present method of accounting. The present system takes far too much time and the quarterly checking of accounts usually throws back other work for about three weeks. He thought it would be better if a branch of the accounts department could be established within the depot. This would avoid a number of mistakes being made with regard to the spelling of different drugs, etc., mistakes which often had important effects. He did not intend that the accounts authorities should be under the Medical Storekeeper, but that special clerks with sufficient knowledge of the technical terms used should be employed on the accounts work of the depot.

Stock-taking was done annually during the month of March. In addition there was a continuous stock-taking, some one article being checked every day. It took very much longer to take stock in a depot than in a business firm, for the reason that there were so many returns to fill up and rules to comply with. He would be able to do things in a very much shorter time if he were not bound down by rules and regulations.

His equipment was pretty well up to date in as far as the requirements of military hospitals were concerned, as a number of articles had been introduced during the war. He would favour the idea of stocking all articles that were required for military hospitals. He did not think this could be done in the case of civil hospitals, as it was impossible to keep pace with their demands for new drugs and appliances.

With regard to the complaints made on account of repairs to instruments, etc., witness stated that this was

due in a great measure at the Calcutta Depot to not having a highly trained staff to carry out the repairs of surgical instruments in the way they should be done. Before the war hospitals used to get out their instruments regularly from Home and there was consequently little need to repair any of the old ones. If he were provided with sufficient money and a better trained staff he could turn out better work.

He did not undersell chemists. In old days he could undersell them, but only on the sale of tinctures, on the spirit used in the manufacture of which no duty had been charged. At present duty was charged on this spirit. In a few things he was a little below the market rate. He thought that Government would shortly lose heavily on the sale of drugs which had been bought at war rates, for when these drugs were disposed of the market rates would have fallen very considerably and Government rates would have to be correspondingly reduced. This state of affairs was largely due to the Controller not being able to keep pace with the changes in the market prices.

The drugs supplied from the Medical Store Depots were much more reliable than those purchaseable in the local market. Everything that came out from Home to the depôts had been first passed by the India Office where it was tested. Very few drugs were examined or standardized in India, except those which were manufactured in the country.

He agreed with the opinion expressed by one of the administrative officers in India that local bodies do not care to obtain their supplies from Government medical store depôts on account of the delay in supplying stores, and the formalities which have to be gone through. The delay was largely due to the fact that all indents had to be checked carefully and such slow checking did not take place when supplies were bought from business firms.

The existence of the Government depôts was a guarantee against sudden rises of price in the open market.

(General Hendley.) At Calcutta, practically all the being called a Medical Supply Department or Depot, and the head of the department being called the Director of Medical Supplies.

He agreed with the suggestion to cultivate certain drugs in India, but he considered that this should be undertaken by the Agricultural Department and not by the Medical Store Department.

(General Hendley.) At Calcutta, practically all the instruments were got out from Home. Those that were purchased locally were often not up to the standard required. Orders that were placed over a year ago for instruments have been uncomplished with. In Calcutta

3 March 1919.]

Lieutenant-Colonel W. D. HAYWARD.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

he had had some complaints about sharpening instruments but in Madras he had none. Some of the complaints received were justified. He thought that the complaints were due to the fact that the instruments were old. He was inclined to revert to the old arrangement by which instruments were got out from England. He did not think that the firms in India (Calcutta) were able to compete with English firms in the manufacture of instruments.

At present the firms in Calcutta had more work than they could cope with. He had received large orders from Lahore and Bombay for the supply of instruments. He did what he could to supply these. In some cases he had to write and tell firms that if they could not supply within a reasonable time he would have to cancel their orders. The quality of instruments manufactured in India was fairly good but their finish bad. There were not at present in India firms who could expeditiously supply instruments in the quantities required. He would, therefore, advocate a return to the old arrangement under which instruments were procured from England.

He favoured the supply to as many hospitals and other institutions as possible of all drugs stocked by the depots as this would render possible a more frequent turn-over. Drugs and articles of equipment out of the usual run and for which the demand was small should, however, be obtained from the manufacturers direct, as owing to the smallness of the demand they could not with advantage be stocked by the depots.

The question of keeping the stores price lists up to date was difficult as the Controller was unable to follow rapidly the changes in market prices. The last time the price list was revised was in 1915. The present system was cumbrous and it should be improved. He suggested that although the check should be maintained in the Director General, Indian Medical Service's office and in the accounts office, the depot should have a

freer hand. A certain amount of discretion should be allowed to Medical Storekeepers.

(Colonel Shairp.) The annual indents received from these institutions had decreased in size and number of items, during the war, owing, he thought, to the uncertainty as to prices. Very numerous small indents were, however, received for supplies which the indenting institutions found they could not obtain elsewhere.

Normally when the quantity of supplies obtained in India was small there was not sufficient work at this (Calcutta) depot for a whole-time analytical chemist. At present, however, one could be employed with great advantage, as the articles purchased locally were too numerous for the chemical examiner to test them all.

He favoured the suggestion for the establishment of one central store with refrigerating apparatus to which all imported rubber goods might be sent for storage and distribution, as required, to military hospitals. This would not be satisfactory in the case of large civil hospitals, whose demands for rubber gloves, etc., varied with the idiosyncracies of the officers appointed to their staffs.

(Mr. Hignell.) After the war there would be a tendency for the quantity of local purchases to decrease rather than increase, in spite of the fact that more drugs might be manufactured in India than at present. The reason was that many of the articles now purchased locally were of European manufacture, and imported by small dealers who sold them to the depots.

(General Giffard.) With regard to the complaint by local bodies on account of the high prices charged for some drugs witness stated that they had probably consulted the old price list of 1915 which was out of date. He was quite in agreement with the suggestion that the Medical Store Depot should do its business on business lines in order to retain business from the various local bodies.

(General Hehir.) He favoured the idea of having secondary depots at headquarters stations of provinces.

8 March 1919.]

Captain R. KNOWLES.

*(The schemes and questions referred to by witnesses are contained in Volume III.)***At Calcutta, Monday, 3rd March 1919.****PRESENT:**S. R. HIGNELL, Esq., C.I.E., I.C.S. (*Presiding*).

MAJOR-GENERAL G. CREE, C.B., C.M.G., A.M.S.

MAJOR-GENERAL H. HENDLEY, K.H.S., I.M.S.

MAJOR-GENERAL P. HEHIR, C.B., C.M.G., C.I.E.,
I.M.S.MAJOR M. T. CRAMER-ROBERTS, D.S.O., Indian
Army.

and, as co-opted members, SIR T. NARIMAN, Kt. and Lieutenant-Colonel BHOLA NAUTH, C.I.E., I.M.S.

MAJOR A. A. MCNEIGHT, I.M.S. (*Secretary*).

CAPTAIN R. KNOWLES, I.M.S., representing the views of the Government of Assam.

Copy of letter no. 209-P. A. T., dated the 25th February 1919, from the Second Secretary to the Chief Commissioner of Assam, to the Secretary, Medical Services Committee, Calcutta.

With reference to your letter no. 17, dated the 28th January 1919, on the subject of the reorganization of the Medical Services in India, I am directed to say that during the last month the Chief Commissioner has been touring in remote parts of the province and has been quite unable to study the problems which are involved. He has, however, placed the Hon'ble Colonel Banatvala, C.S.I., at the disposal of the Committee in the capacity of a co-opted member, and Captain Knowles, I.M.S., in the capacity of an official witness. Sir Nicholas Beatson-Bell has much confidence in the ability and judgment of both these officers. He understands that the views of Colonel Banatvala as embodied in his letter no. 1911, dated the 20th February 1919 (reproduced below), have already been communicated to the Committee. It was only yesterday that Colonel Banatvala's letter reached the Chief Commissioner's Camp, but Sir Nicholas Beatson-Bell is prepared to give his provisional concurrence to the general conclusions of that letter.

2. From the point of view of Assam it is important that the Committee should obtain the opinion of the medical officers of the tea planting community. If arrangements for this have not already been made with the Indian Association, the Chief Commissioner would suggest that the Committee should examine Dr. Douglas Cameron who is at present one of the leading private practitioners in Calcutta and was formerly a garden doctor in the Lakhimpur district of Assam.

3. The Chief Commissioner regrets that he is not in a position to place the views of the local administration before the Committee in a more detailed and reasoned form. There is, however, one aspect of the case which is, in his opinion, of paramount importance, namely, that in every locality where there are British ladies there should be at least one fully qualified British doctor. He regards this as essential to the continuance of India "as an integral part of the British Empire."

Copy of a letter no. 1911, dated the 20th March 1919, from the Hon'ble Colonel H. E. Banatvala, C.S.I., K.H.S., I.M.S., Inspector-General of Civil Hospitals, Assam, to the Second Secretary to the Chief Commissioner of Assam.

I have the honour to acknowledge receipt of your memoranda no. 609-M. of the 3rd instant, no. 717-M. of the 10th instant, no. 758-M. of the 12th instant, and no. 904-M. of the 18th instant, forwarding, for my opinion, copies of letters no. 17 of the 28th January 1919, no. 27 of the 3rd instant, no. 1—7 of the 7th instant and no. 1—14 of the 11th instant, and their enclosures, from the Secretary, Medical Services Reorganization Committee.

I have not had time to consult all Indian Medical Service officers on the subject within the very short time that has been allowed me for reply, a condition I consider as being unfortunate as their future prospects are necessarily involved whichever scheme is finally adopted. All they have been able to see is letter no. 17 of the 28th January. I have not been able to send them copies of the four schemes referred to in the letters as they were received too late.

I now proceed to give my opinion on the questions raised in letter no. 17, from the Secretary, Medical Services Reorganization Committee.

Taking each question in order:—

- (i) I consider it is desirable that unified superior medical service should be created in India. The duties to be undertaken by such service to be:—
 - (a) all duties at present undertaken by the military side of the Indian Medical Service.
 - (b) all duties at present undertaken by the civil side of the Indian Medical Service.

(c) all duties at present undertaken in India by the Royal Army Medical Corps.

(ii) Scheme B—with modifications—seems to be the best of all four. The details of this scheme are criticised below.

(iii) The three services, *viz.*, the unified superior medical service, the Indian Medical Department and the service of sub-assistant surgeons should be distinct and separate; but promotion from no. 2 to no. 1 and from no. 3 to no. 2 should be given in the case of deserving officers.

(iv) The maintenance, in civil employment, of an adequate war reserve in the ranks of both the superior and the subordinate services is both necessary and feasible. The call to military duty in case of emergency should be made a condition of service in civil employ in these ranks.

(v) As regards the relationship of independent medical practitioners in India to the unified service, the suggestion is put forward that the example of the special medical reserve (T. F.) in England before the war should be followed. That is to say independent medical practitioners, both European and Indian, should be enrolled in a voluntary special medical service; should be given military rank and an annual monetary allotment on condition that they are liable for military service when called upon and that they

3 March 1919.]

Captain R. KNOWLES.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

attend camps of instruction or annual manœuvres. Should the Indian Defence Force be maintained, its medical personnel would most suitably be found from such a source. It is probable, in view of the experience of the war, that sufficient men would be forthcoming to form an adequate war reserve in the ranks of the superior service.

- (vi) The Medical Store Department needs to be enlarged and reorganized. At present several drugs in common use (such as thymol and oil of chenopodium) are not available; nor is bacteriological or laboratory equipment available except for an occasional and stray article. Local governments would be willing to purchase their medical and surgical equipment from the depots of Government Medical Stores if there was a reasonable prospect of that department keeping pace with the times, and stocking the newest remedies and instruments and appliances.

I now proceed to discuss scheme B in detail :—

I agree in the opinion expressed in paragraphs 1, 3 to 5, 7, 9 to 11, 16, 19, 21 and 22.

Paragraph 2.—The increase of medical officers serving with the Indian Army from the present percentage of 1·2 per mille to 3 per mille of its strength is very necessary, and, indirectly, it will benefit the whole country and will enable officers to get their leave—for purposes of study and recreation—oftener than they are able to at present.

Paragraph 6.—I do not consider the grant by Government of scholarships for Indian medical students and members of the domiciled community desirable, as there is always the risk of the students failing to carry out the object for which the scholarships are given. I think this should be left to private charity.

Medical education in India has suffered from lack of efficient training in obstetrics and gynaecology more perhaps because of the want of opportunities owing to the conditions peculiar to the country, and I consider it absolutely necessary that in the case of a candidate for the competitive examination who has obtained qualifications in India, a certificate of proficiency in these subjects should be produced by him after a course of practical training in hospitals in England for the reception of obstetric cases or of the diseases peculiar to women and children. Incidentally, it will mean a longer stay in England for such candidates—a very desirable condition.

Paragraph 8.—I consider there should be only one head of the unified medical service in India—both military and civil. Whether he is called Director, Medical Services or Director General, Indian Medical Service, is a matter of indifference. Further, in consideration of his duties in the civil department he should be Secretary to the Government of India in the Medical Department.

Paragraph 12.—I do not agree with the proposal, as by allowing him to elect for the civil department you lose the services of an efficient officer for military duties. It is necessary that he should not lose touch with the military side of his duties throughout his service in the civil department, and with that in view he should be made to go through a course of training of from 6 weeks to 2 months every 3 years either at camps of exercise or wherever it may be decided to send him without loss of his civil appointment.

Paragraph 13.—I am not prepared to accept the principle of "residuary" appointments. There should be none anywhere. It is all a question of medical fitness and the ability to replace them and I consider that within from 10 to 15 years there ought not to be any difficulty in this respect. I do not see why it should not be possible

to withdraw every officer of the unified medical service in a war emergency from his civil medical duties. The only condition against it would be physical unfitness.

Paragraph 14.—All promotions to the administrative grade should be made by the head of the department and not by the local government. He is the only officer who has the whole history of services of all officers of the department, their confidential reports, the courses of special study they have attended, etc., and is in the best position to judge the comparative merits of his officers. The local government can only promote from among the officers in civil employ in its own province, and this is not intended.

There should be one universal roster for civil duties.

As regards the position of the Director General, Indian Medical Service, please see reply to paragraph 8.

Paragraph 15.—I do not agree. As stated against paragraph 13 above, all officers—with the exception of those physically unfit—should be liable to recall to military duty.

Paragraph 20.—I consider the School of Tropical Medicine, Calcutta, is obviously the best and most suitable place for such training. Once this school is started the absurdity of our having to go outside India—whether to the London or Liverpool Schools of Tropical Medicine—should cease.

Please see remarks against paragraph 12 with regard to military training.

The opinion expressed in the last sentence is, in my opinion, not sound. There should be no frequent interchange between the military and civil sides of the service up to 20 years, as it would be an extremely bad arrangement for the civil medical side. All that is required will be served by the periodical military training recommended against paragraph 12.

Paragraph 20.—I consider the Tropical School of Medicine, Calcutta, is obviously the best and most suitable place for such training. Once this school is started the absurdity of our having to go outside India—whether to the London or Liverpool Schools of Tropical Medicine—should cease.

I suggest that every officer of the unified service should, on arrival in India, be made to go through a six months' course of training at the Calcutta Tropical School and the Medical College and Presidency General Hospitals. At the two latter institutions he would see diseases, both medical and surgical, peculiar to the tropics and their treatment.

Paragraph 23.—I think the proposal of having two medical officers in every headquarters station of a district is both extravagant and impracticable and is likely to lead to trouble. I consider the question to be one of the "personal factor." If the Indian medical officer has a practical experience of obstetrics and gynaecology—in other words—if he is good at his work there is no difficulty and no objection. The course of study suggested before a candidate with Indian qualifications is allowed to compete for the examination ought to improve matters.

I consider the last sentence of this paragraph is very sound. There will be a number of suitable and lucrative openings for doctors after the war, not only in England but in the Colonies, and with the dread of the Indian Reforms Scheme coming into operation early in the country I doubt if there will be many British candidates for the competitive examination unless the pill is heavily gilded.

Paragraph 24.—To enable officers to keep touch with the latest advances in the practice of their profession it is necessary that they should go to Europe on "Study duty" once every 7 years.

Paragraph 25.—I agree generally, but particularly with the last sentence.

Answers to questions by COLONEL BANATVALA.

Questions for witnesses.

1. In my opinion the Royal Army Medical Corps being a purely military service, affords its officers in-

sufficient opportunity for becoming acquainted with tropical diseases, especially as its officers are removed from India just as they are beginning to become acquainted with the country and its special diseases. The

3 March 1919.]

Captain R. KNOWLES.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

civil side of the Indian Medical Service is in insufficient touch with modern military requirements and training.

Yes; scheme B with modifications as suggested in letter no. 1911 from the Inspector-General of Civil Hospitals, Assam.

2. It will probably meet the needs of the army in India, at least as regards the superior service.

3. It is doubtful. The probable conditions at Home within the next few years must be frankly faced. As a result of the war (a) there will be a serious shortage of medical men in the United Kingdom; (b) the probable introduction of English State Medical Services under the Ministry of Health will absorb the best men from the Home medical schools; (c) the return of millions of men from tropical and sub-tropical climates will create a special demand for doctors conversant with tropical diseases; whilst (d) a practical boycott of the Indian Medical Service has now existed for some years in the Home medical schools on account of the inferior prospects held out by the service as at present constituted. Under such conditions, and for some years, until the new unified service has an established position and reputation the entries from the medical schools at Home for competitive examination may be few or nil.

As regards the entry of Indians, although competitive examination may appear peculiarly congenial to the Indian temperament, yet it is doubtful whether it results in the selection of the best class of candidate.

In my opinion, entry for at least some years may have to be by nomination and selection. On the other hand, if the competitive examination be retained, then it should be made far more practical in character than at present.

4. The efficiency of medical administration in the country has certainly suffered.

5. Probably. A larger cadre will mean more men for civil employment, and the medical needs of the civil population of India will always absorb as many capable men as will be forthcoming.

6. Yes; at least in the superior service. A special medical reserve, for both independent European and Indian practitioners should be established on the lines of the special medical service, T. F. in England before the war.

7. Yes, emphatically. It should be in India, as in time of war it will have to do duty in India or with Indian troops.

8. It has met the demands made upon it, and has been of the greatest value. In employing such a body of men, however, special attention should be paid to special qualifications; e.g., a civil surgeon with many years of operative experience would be best utilized as operative specialist in a large war hospital, a bacteriologist in laboratory work, and so on.

9. Candidates must possess qualifications registrable under the General Medical Council of the United Kingdom and Ireland. In the case of Indian candidates evidence must be given of training in gynaecology and obstetrics, preferably in an English or Irish Medical School. Entry should be by an open competitive examination of an essentially practical nature, if possible; if, however, a sufficient proportion of English candidates is not forthcoming, then by nomination and selection.

10. It should be made feasible and compulsory for every member of the service to spend at least six months of study duty at an English Medical School once in every seven years, or more often.

11. The research department should be centralised under the Imperial Government. Each province should possess its own provincial laboratory: and no routine work should fall upon the men in the special research departments. Pasteur Institutes could be suitably combined with such provincial laboratories, and a central vaccine and serum institute set up for all India, to make all vaccines and sera required with the provincial laboratories as distributing centres. The research department would then come directly, as regards finance, direction and control under the Imperial Government. It should have its main large laboratories in the great cities where there is open access to abundant

clinical material with travelling laboratories for the collection of special material and the study of localised outbreaks of special diseases. To be of maximum value, research work must be (a) in touch with ample clinical material; and (b) centrally directed, controlled and co-ordinated. Both military and civil needs, as regards research, should be met under such a system; while the present custom of overwhelming research workers with routine work, to the detriment of their usefulness and value, should cease.

12. It has declined very seriously. The specialist medical officers in the large cities and the civil surgeons in hill stations still appear to have considerable practices to the detriment of their work for the State. The civil surgeons of the smaller mofussil districts have little or no private practice although their scale of pay was fixed years ago on the supposition that they would draw considerable sums from private practice. The bacteriological worker is occasionally in request to undertake private work, when he would rather not. The chief reasons for the decline of private practice are (a) the growth of an independent medical profession in India, which is rightly absorbing much of the private practice; and (b) the ever increasing number of duties thrust upon the civil surgeon, who has less time than formerly for private practice. In my opinion,—as regards the bacteriological side, at least,—it would be to the advantage of the State to debar officers from the right to private practice; but—if this is done—suitable compensation in lieu should be given.

Questions to be asked of service officers.

1. At first four years in military service, from date of commission; then two and a half years in civil; then two years of military service on war duty; then two and-a-half years in civil.

2. Yes. (a) During my first few years in military employment incessant transfers, involving the loss of private means. The introduction of the Indian station hospital system will, fortunately, put an end to such grievances. (b) Inability to take furlough for monetary reasons. (c) The fact that, after eleven years of service, I have never yet held a substantive appointment.

3. Yes.

4. I consider the introduction of a single, unified service as the best remedy.

5. (a) Three years.

(b) An officer should be liable to recall to military duty as and when required. To remove men from civil work, however, just as they are beginning to be of real value in civil employment, would be to the detriment of the whole medical administration of India.

Special questions.

1. Partly to racial predilection but chiefly to the fact that the man trained in India has not received a sufficient training in gynaecology and obstetrics. If Indians of the right social status be appointed, and if a thorough practical training in gynaecology and obstetrics be insisted upon, the difficulties will largely disappear.

2. It has depended on the medical men appointed. In Assam men with Calcutta qualifications have done very well; on the other hand some have been less satisfactory. From the executive point of view the Indian substitutes have been unsatisfactory, with some few exceptions. The right class of Indian with proper qualifications is welcomed. Where such have not been available Europeans have, occasionally, gone to private European practitioners or doctored themselves.

3. Varies very widely. The standard is not nearly as uniform as among European officers of the medical services.

Medical Stores Department.

1. (a) Annual indents mostly from England (except for tinctures and spirits; castor oil; quinine; opium and some acids).

(b) Emergent indent mostly from Calcutta firms.

3 March 1919.]

Captain R. KNOWLES.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

2. The civil surgeon; but he has not a free hand. Under the local self-government Act Rule 133 (i), the civil surgeon may not order medical stores on behalf of the local board without the Chairman's previous approval, except in very urgent cases when the fact has to be immediately reported to the Chairman.

(b) There would be no objections to such an arrangement.

3. In my opinion the Medical Stores Department needs to be enlarged and re-organised. At present several drugs in common use—(such as thymol and oil of chenopodium)—are not available except from outside sources. Bacteriological and laboratory equipment is not available at all—(except for a very few articles and then only for military hospitals). A properly re-organised Medical Stores Department would (a) mean considerable economy because purchasing in bulk would replace widespread purchasing in detail; (b) secure more speedy, more uniform and more reliable service and supplies; (c) be in a position to lead instead of follow the introduction of new and synthetic drugs and new equipment; and (d) take up the very important problem of the sources, manufacture and supply of drugs and equipment made in India. To give an illustration, it is anomalous that rubber "serum caps" which are wanted by the gross at every Pasteur and Vaccine Institute in India should have to be imported from England. If the Medical Store Department would take the lead in the introduction of the newest and best remedies and equipment its value to the medical services in India would be incalculable. At present the Department follows the lead—at a very considerable interval.

Questions to be asked of officers regarding assistant surgeons and sub-assistant surgeons.

1. Copy* of the bond is attached. (b) No. (c) Yes; their liability for military duty should extend throughout the whole of their service. If necessary, an addition should be made to their pay on this account. (d) The figures for Assam are as follows:—

Liable to military service, as having less than 5 years' total service on the outbreak of the war 27·2 per cent. of cadre.

Asked to go to military duty 39·4 per cent. of cadre.

Went to military duty 31·7 per cent. of cadre.

Refused to go to military duty 7·7 per cent. of cadre. or 28·3 per cent. of those liable to military service.

2. *Vide* paragraph 1.

3. As far as Assam is concerned the conditions of service are fairly satisfactory; but an increase in pay is recommended.

4. (a) I am instructed to state that it is the opinion of the Inspector-General of Civil Hospitals, Assam, that, in the event of war, the mortality rate of the province

would not be appreciably increased if every dispensary in the province were closed down, with the exception of those at headquarters of districts and sub-divisions, since the branch dispensaries can only deal with minor medicine and minor surgery.

(b) The number employed could with advantage be increased. (c) They should be employed especially in connection with travelling dispensaries and in the Sanitary Department. (d) In withdrawing men for military duty they should, as far as possible, not be removed from the Sanitary Department.

5. Yes; and for the whole of their service.

6. No. An increase in the number of travelling dispensaries is essential, even if it should mean the closing down of small permanent branch dispensaries. There should be a commissioned medical officer in each district—in addition to the civil surgeon—to supervise and control the work of the travelling dispensaries.

This officer should work in collaboration with the civil surgeon, and he should have an assistant directly under him of the civil assistant surgeon class.

7. They should be resident medical officers of the Indian station hospitals.

8. He should have less clerical work and more military training. A better class of man should be sought for. The military sub-assistant surgeon should be better paid. His status and rank should be improved.

9. The civil sub-assistant surgeon was probably more efficient as regards professional work.

10. (a) Yes. (b) Yes.

11. *Vide* paragraph 8.

12. Yes. He could only be replaced in all non-professional duties.

13. In Assam, of 8 military assistant surgeons employed in the civil cadre, 7 were withdrawn for military duty and the 8th was found unfit for military service by a medical board.

14. He would be usefully employed in Indian military hospitals, in such departments as the Medical Stores Department and in Research and Pasteur Institutes and provincial laboratories. He would be of use also in civil employment generally.

15. His professional training leaves a good deal to be desired and should be improved. If the service were made more attractive by higher pay, and by better prospects of admission to the superior service then recruitment should be continued.

16. Yes; certainly.

17. More or less as at present; but see paragraph 14. He should enjoy full facilities for promotion into the superior service, if his work merits it.

18. *Vide* paragraph 15.

CAPTAIN KNOWLES, called and examined.

(President.) The witness represented the views of the Assam Government, and those of Colonel Banatvala. He favoured scheme B.

There should be a unified medical service in place of the Indian Medical Service and the Royal Army Medical Corps. The number of medical officers serving with the Indian Army should be 3 per mille, the present proportion of 4 per mille in the case of British troops being maintained. There should be a special war reserve consisting of independent medical practitioners. There were 26 independent European medical practitioners in Assam, the number being larger than in any other province. There were 13 Indian Medical Service officers in civil employ in Assam in peace time. There were only two big station hospitals.

The hospitals in Assam were mostly Government hospitals. There was no hospital which was worked

only by a district board. There were some which were partly assisted by the district boards, and derived part of their income from Government and part from the district board funds.

The Assam Government intended to increase the number of travelling dispensaries and desired to provide a large number in each district. The system was of recent origin, the first travelling dispensary having been established in 1913. These were very popular among the people.

The circumstances of Assam were rather peculiar and the number of European practitioners there was comparatively large. There were not a large number of Indian medical practitioners either in the bigger towns or in the mufassil. Their number was on the increase.

3 March 1919.]

The Hon'ble Major-General W. H. B. ROBINSON.

(The schemes and questions referred to by witnesses are contained in Volume III.)

THE HON'BLE MAJOR-GENERAL W. H. B. ROBINSON, C.B., I.M.S., Surgeon-General with the Government of Bengal.

*Written statement.**Replies to questions for witnesses.*

1. I have had little to do with the Royal Army Medical Corps in my service. It is many years since I served with an officer of that Corps in India, so can offer no suggestions.

The Indian Medical Service.—After inadequate pay of which so much has been said for many years, the next most crying grievance was the inability to obtain leave, either furlough or privilege leave. Many officers having two to three years due to them before they had any chance of leave and then only after they were permanently in civil employ. It is well known for many years furlough was unobtainable; study leave only made matters worse by putting others back; this was entirely due to the smallness of the leave reserve, only 20 per cent. officiating officers not counting.

Sickly men who broke down scored at the expense of their healthy brethren. At one time a few years ago under a certain local government there were four majors with respectively 2 years and 10 months, 2 years and 10 months, 2 years and 7½ months and 2 years and 6 months' leave due to them. I recently heard of an officer who with 4 years and 5 months due to him he was refused 6 months' leave. (This may be taken as a pretty serious defect.) Most of us in civil have hardly averaged 3 years' furlough in our 30 years' service.

As mercantile firms find it pays to send their staff Home every five years at least, Government might help with an increased leave reserve and free passages for families and officers at least four times in our service. British East Africa has found this to pay, as well as several Colonial Governments.

Shortened term of service for full pension, say, 27 years, when officers enter at an average age of over 26, would be fair; it would improve the flow of promotion and we would not then see officers promoted to administrative rank at nearly 55 as one does now-a-days. Nothing has ever been done to help to clear our block by offering earlier full pensions, etc. Administrative pensions at four years instead of five.

Scheme B seems most suited to India from the civil point of view; this mostly concerns me; none of the other schemes A, C and D would suit civil employment; limited periods of service in civil useless; frequent reversions ditto; no local government could stand it. The cost of scheme B is certainly against it. Local governments will not accept increased cost, even if billed as a good insurance. Cheapness is all popular with such heavy educational and sanitary demands, etc.

2. Doubtful, but this I cannot say, it should meet Indian Army needs; these up-to-date have been few and little fostered. However, things may have changed and the "barrack and charpoy" era may be over. I must oppose any scheme which is determined to smash up a service like the Indian Medical Service and would still be if only reasonable demands had been listened to. It is doubtful now if any of the medical schools will permit their men to take up Indian work, with the prospect of Reforms, more so.

3. Of this I am very doubtful. I hope it should meet these to a certain extent, but so much leeway has to be made up that I am more inclined to think the efforts will be futile. We want much more than commissions and promises; we have had these for about 15 years with little improvement. The treatment given to capable Indian Medical Service officers on service during the War has also not heightened the popularity of the Indian Medical Service as a life-long service.

4. (a) Have no knowledge, (b) on civil districts, the effect has been a steady and slow disintegration. This was not to be greatly wondered at men who had no administrative training and little prospect of ever

being civil surgeons or jail superintendents were pushed into jobs above their calibre. However, I think they loyally tried to do the best. The Inspector General of Prisons will speak on this. The judicial side also complain of a falling off in medico-legal work. This is a point a judicial officer might be consulted on.

5. I think so; all civil assistant surgeons might do a military training course of say six months. War on a large scale would hamper us again in the same way as the late War if our commissioned officers were withdrawn. However, we would now know what to expect.

6. We must make a larger civil reserve from men in Government employ as assistant surgeons; this with some trouble would, I think, be workable but officers who have served long in Bengal do not think so, and say we would only get freshly qualified men, anyway for some years, our late "Temporaries" would come out to some extent. Once a definite scheme is adopted and we are told to work it, I dare say we will find the way. It is very hard to say how any theoretical scheme will work in India and one does not like to be too optimistic.

7. Naturally I am in favour of a previously trained reserve as far as possible. I should like to see the reserve in India.

8. From the way they were called for I suppose they must have been some use; the military side got many good men but whether they utilised them as well as they might I know not. This would probably be better next time.

9. Home recruitment undoubtedly; transferred and seconded Royal Army Medical Corps officers. I am not in favour of simultaneous examinations for Indians with only Indian qualifications. They have no training in special subjects, midwifery especially. If admissions in India be taken the candidates should go Home for at least two years. The ordinary Royal Army Medical Corps training, possibly at an Army Medical School in India or at the Calcutta Tropical School and Hygiene Institute when ready. Periods of study leave if a proper leave reserve provided.

10. Is too casual at present; some laid-down line should be followed. Short post-graduate courses in India also would be advisable at an Army or Indian Army Medical School.

11. Special research has been dealt with by a committee of experts and their report might be awaited or consulted.

12. See Public Services Commission. The main reason is that there are so many Indian practitioners capable of attending their countrymen. There is practically nothing left in the ordinary district station. The days of private practice for officers are gone outside the presidency towns and one or two special places. I don't think the average for the whole service runs to Rs. 200 a month now.

Service officers' questions.

1. Military about 11 years, civil about 22.

2. Nothing special; loss of pay; interference with private practice, this affected my branch (Foreign Department) seriously; leave difficulties.

3. No knowledge.

4. 33 per cent. pay increase without any more delays.

Up-to-date leave rules, proper civil reserve. Shorter period of service for full pension. Non-interference with private practice rights. With reference to Reform proposals, pensions guaranteed by statute; permission to retire on proportionate pensions if conditions become untenable; this is a point all younger officers particularly request impressed.

5. Transfers military to civil about four years to six; this depends so much on vacancies under local

3 March 1919.]

The Hon'ble Major-General W. H. B. ROBINSON.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

governments that no one period can with any fairness be fixed.

Civil to military, if full period of service shortened to say 27 years, I would adopt the 20 years period; but to safeguard existing interests for all officers now in service I would suggest—"when selected to the higher lieutenant-colonel grade." It has not been made clear in any of the schemes or proposals that hardly any civil officers ever wanted military promotion; this was forced on us, also that the few purely military members of the Indian Medical Services ever reached administrative rank; the poor class of work they did, for 28 to 30 years in a regiment, rendered them unfit for promotion and the civil was thus called on to fill the administrative military billets. Men in civil were forced to take the military administrative billets or resign the service and lose their full pension; this should not be forgotten when the Indian Medical Service administrative officer is being found fault with; so by all means if a man wants a military promotion let him go back a year or so earlier and get up-to-date in military work. No one ever believed in the two months' training. Men who do not want military promotion should at the time they get on the selected list be given an opportunity of electing to stop in civil to the date of full pension.

Special questions.

This question should better be answered by some of the civil officers whom it really concerns. It is not for us to reply. No doubt very strong racial feeling exists.

2. No, they certainly have not. By doing without or coming to one of the presidency towns, etc.

3. Service not clear. If service generally, I believe the academic qualifications now-a-days are higher than 25 to 30 years ago.

Stores.

Medical Store Depot and open market. Only 3 such institutions are supplied from Medical Stores, Kalimpong Missions, Howrah Hospital and the Calcutta Dufferin.

2. The superintendent, countersigned by surgeon-general. It would not fall in with ways of local bodies. Especially for emergent demands, too much red tape, poor stocks, old stocks, delays; not what you want but what Medical Storekeeper has to give or wishes to get rid of.

Have had very little to do with such. Much waste of time and paper over present indent form. Too much encouragement to ask for useless substitutes. In its present state it could not satisfactorily serve a multitude of local institutions; would lead to much friction.

Officer's question regarding military assistant surgeons and sub-assistant surgeons.

1. * Form attached. Yes, has been enforced for sub-assistant surgeons and penalty realised.

2. Possible but undesirable and unpopular.

3. Yes, fairly so at present.

4. It supplied 17 assistant surgeons, 20 temporary assistant surgeons and 104 sub-assistant surgeons; no serious trouble; assistant surgeons plentiful and generally a waiting list.

Sub-assistant surgeons somewhat scarce during war as they feared and disliked war service, and pay was poor, Rs. 30 per mensem. Yes, if cost not to count. Not seriously in this province.

5. No, if treated properly as qualified men and given temporary commissions, junior or recently qualified men will be forthcoming. Five years.

6. Fairly well, it is a matter of money. I do not think so. The provincial Bengal service are fairly contented; requests for conditions suggested by Public

Service Commission are now coming forward. These should be accepted.

7. He can act as a resident medical officer in a station hospital; he should be relieved of all clerical and accounts work. Too much trained professional energy is wasted in routine babu work. I think so; can also be used for sanitary work as a supervisor or inspector.

8. Cannot say; here we train for professional medical work.

9. Cannot say.

10. Cannot say; do not know what proposals are for running military hospitals under new schemes. The latter part of the question does not seem clear.

11. Sub-assistant surgeons have many requests, and now expect to be treated as qualified men, paid properly, given increased family pensions, better status, housing, leave, and many other improvements. This has been the result of the passing of the Medical Degrees Act, which now recognises them as legally qualified medical men in India. See recent numbers of the "Indian Medical Journal," their accredited Journal.

12. Cannot say.

13. (a) I do not know. (b) All our military assistant surgeons were withdrawn except a few men over age or recalled from pension.

14. As deputy superintendents in jails, lunatic asylums, large hospitals and schools, railway appointments, sanitary and such like. Unless holding a British registrable qualification I do not approve of their being made civil surgeons; unless qualified there may also soon be difficulties when giving evidence in Courts of Law.

15. They should be made to take the Membership qualification, have a five years' training and a proper educational standard; the Licentiate Standard of Faculty here not sufficient as it does not enable them to take Home qualifications later. Yes, as at present educated.

16. Certainly.

17. Then he could be utilised as at present, or given a commission in the unified service, after passing the usual competitive examination. Or possibly be appointed direct after some years' service in subordinate grades.

18. No experience. As a class I would be sorry to see the military assistant surgeon gone; is most useful in many civil billets where any administrative talent is wanted. The railway population also approve of him and much prefer him to qualified Indians.

Criticisms of the four schemes.

Scheme A advocates total abolition of the Indian Medical Service, and its replacement by a subordinate service known as the auxiliary service. It is obvious that such a service cannot take the place of the present service which consists of highly trained and much experienced surgeons and physicians who do 90 per cent. of the medical and surgical work in India and are largely responsible for the health of the country.

Scheme C advocates separate military and civil medical departments. It would combine Royal Army Medical Corps and Indian Medical Service as an Indian Medical Corps, the civil side being formed of officers seconded from military. It is considered essential that reversion from civil to military should take place for one year after five years in the former department. This is bound to be unsatisfactory; keen professional men will not come into a service where professional work is periodically relegated to the back-ground. Military efficiency is not likely to be increased, and local governments will strongly object and with good reason too.

Scheme D advocates an Indian Medical Corps and would only allow 10 per cent. of the civil medical service to be filled from the Corps. This will attract nobody. The one great attraction and "draw" of the Indian Medical Service is the opportunity of getting into civil life with all its professional attractions.

3 March 1919.]

The Hon'ble Major-General W. H. B. ROBINSON.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

All the above schemes A, C and D insist in common on one point, *i.e.*, the absolute necessity of appointing large numbers of specialists for the new service. It appears then that with the abolition of the Indian Medical Service it is thought necessary to institute a Corps of consultants, obviously to replace the former.

It is very certain that if any of the above schemes are carried out the high professional type that was characteristic of the Indian Medical Service will totally disappear and a mediocre substitute will take its place; he may be good enough to carry on routine hospital work, to fill in forms, inspect cook-houses and latrines and even to advise on sore feet and gonorrhoea, but he will be in no wise able to carry on the highly specialised and skilled professional work that was characteristic of the civil side of the Indian Medical Service.

Scheme B with modifications might be converted into a workable proposition. Difficulties will arise in connection with the suggestion to have an European or commissioned medical officer at each district headquarters. This is hardly feasible, but other arrangements can be made. The scheme will be an attractive one for recruits and may go far towards again drawing the sort of man that is admittedly required, *i.e.* the best class of doctor, European or Indian. The question of a war reserve is workable. Military training can be arranged in connection with periods of furlough or study leave or at time of promotion. All the officers—or most of them at any rate—in civil employment are highly specialised in some branch of medicine or surgery, *i.e.*, general surgery, ophthalmology, parasitology, radiology, etc. In time of war, then, let these officers be sent to the army as consultants and specialists in their own particular work. During the present war enormous salaries were paid to consultants from Home who had no military training and whose experience in many cases fell far below that of many Indian Medical Service officers in civil employ. It is quite easy with six months' training to make suitable civil Indian Medical Service officers efficient in administrative military work.

An Indian medical college is of great practical importance. It would probably be advisable to send newly recruited officers from Home for instruction to it rather than to Millbank. Certainly all officers before going to civil should have the benefit of a course. Frequent post-graduate courses of short duration for officers of all lengths of service and standing should be arranged.

Of the four, scheme B appears to be the most acceptable and with a certain amount of modification could be turned into a scheme that would fulfil the conditions and hopes mentioned in paragraph 1 of the proposals.

Paragraph 2.—Stands as proposed.

Paragraph 3.—More officers in civil employ. This will be contrary to the Morley rulings. However, as under the new Reform scheme, a much greater number of Indians will be recruited into the Indian Medical Service and as it has been thoroughly proved that the private independent medical practitioner requires no fostering, it will be possible to give employment to a larger number of Indians seconded from military, as civil surgeons, health officers, etc.

To provide a war reserve more commissioned officers must be employed outside military duties.

How can this be attained?

1. The ordinary civil surgeons of pre-war days must be filled up with seconded Indian Medical Service officers.
2. The Health Department, Sanitation, etc., to employ at least one commissioned officer per district.
3. All large towns, cities, to be given a health officer.
4. Teaching, college appointments, bacteriological, special research, etc., to be manned by seconded Indian Medical Service officers.

To make it possible to get men to go to these appointments, officers must be properly paid, as private practice is practically non-existent. Also, liberal leave

must be allowed and this will entail a liberal reserve to enable leave to be obtained when due.

Paragraph 4.—A matter of computation to be worked out when the standing garrison is known.

Paragraph 5.—If we are to have a unified service for India the sooner it is done the better. Therefore, there should be as little seconding from the Royal Army Medical Corps, after the transition stage, as possible. At first efforts should be made to secure the required number of Royal Army Medical Corps officers thought necessary to look after the British troops. This should be done as far as possible by—

1. Selection from those volunteering to join the Indian Medical Service.
2. Seconding Royal Army Medical Corps officers for different periods 1, 2, 3, 4 or 5 years as desired by them, and as found suitable with reference to their age, rank, etc.
3. Opening the service to properly qualified men with Indian experience, particularly those with war service—European or Indian.
4. Recruitment by examination, or even nomination at first, if necessary.

Those seconded would not be permanent Indian Medical Service officers.

Paragraph 6.—To stand down to the last sentence regarding scholarships for Indian medical students and members of the domiciled community. Practically no military assistant surgeons possess registrable European qualifications.

Suggestions.—The medical colleges—Principals and Councils—should select double the number of candidates required for each year at the end of the third year of the medical course.

A competitive examination should be held each year, after the selected students had passed the 1st M. B. of their University and the D. G.'s examination for students on probation for the Indian Medical Service.

The scholarships should be tenable for three years and should be of value sufficient to cover the cost of finishing the students' medical education at Home.

Paragraph 7.—Stands. As it is hoped to get a large number of volunteers from the Royal Army Medical Corps the matter is not important.

Paragraph 8.—The head of the service must be an Indian Medical Service officer. It has hitherto been a real grievance that the Army Medical Service have always held the appointment.

During the transition period if an officer of the Royal Army Medical Corps with Indian experience is of outstanding merit, and is seconded and has served with the Indian Medical Service in India he may be selected.

Paragraph 9.—All officers working in India, seconded or *pucca* Indian Medical Service should draw the same pay and allowances rank per rank.

"Seconded" officers would be entitled to free passages for themselves and families at the end of their tour of service.

The same rules should apply to all officers recruited at Home. Nothing would do more to popularise the Indian Medical Service than a guarantee that once every five years of service leave would be given and free passages allotted to officers and their families.

It is only asking the State to do what the majority of European firms are glad to do in order to keep their staff fit and contented.

Indian members of the Indian Medical Service would similarly get travelling allowance to their homes once every four years of service.

Paragraph 10.—Stands.

Paragraph 11.—Stands.

Paragraph 12.—Men in civil should decide by the time they come on selected list, or at 25 years' service, whether they wish to accept military or civil promotion.

Paragraph 13.—Many of the officers who would hold residuary appointments, such as professors of surgery, medicine, bacteriology, hygiene, etc., might form a very valuable temporary reserve as consultants in case of war, say in India. Their places

3 March 1919.]

The Hon'ble Major-General W. H. B. ROBINSON.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

could be filled temporarily by the other members of the college staff. This was done at Home and men in similar appointments in Britain gave valuable assistance to those at the front in France and in the large hospitals nearer Home.

The holders of residuary appointments would, whilst holding them, be lost to the army, except as above, as consultants. They should therefore select by 20—22 years' service or when placed on the selected list for civil or military promotion.

Paragraph 14.—So long as the status, extra pay and pensions are secured the question of rank is not so important, except socially.

Paragraph 15.—This would never do. Many most valuable civil surgeons do not want residuary appointments. The same rules should apply to all. Declare at 20—22 years, whether they want to return to military or stay in civil. If a man is militarily unfit and is competent to perform civil duty he should certainly be retained. Bengal has been practically run during the last four years by those of this class.

Paragraph 16.—There must be strong war reserve, composed of Indian Medical Service officers employed in civil posts. For this purpose a large number of new billets will be required. These will be necessary for the health and happiness of the civil population: health officers, experts in all subjects, teaching billets, bacteriological research in many branches hitherto untouched in India. In peace time large numbers of officers could be employed in investigating the prevalent diseases, cholera, plague, diabetes, ankylostomiasis, malaria, kala azar, etc. Laboratories set up to investigate indigenous drugs, etc.

Regarding the formation of a further reserve from the private practitioner and assistant surgeons:—

- (1) Regarding private practitioners, it is hopeless and useless. Only those recently qualified and who have not settled down would ever think of joining up if called on. After a few years, family ties and racial tendencies become too strong and they cannot go if they would, and are often unfit from a physical aspect even though willing.
- (2) Regarding those in civil employ—assistant surgeons and sub-assistant surgeons—the case is different. Although here again the greatest difficulties will be met with. However, a course of training in a military hospital and at the Army Medical School could be arranged. It would be necessary to make it part of their contract that they would be liable for military service. A yearly medical examination for physical fitness would be required and a small extra honorarium might be given in addition to the ordinary pay for those who kept themselves efficient.

Paragraph 17.—No comment up to "one of the worst features....." so, it is said, but one has difficulty in seeing how a man who stayed in military has had any better chance of becoming efficient. In fact far more the other way. The man in civil has had far greater experience in running a district, a big hospital, etc., and as for returns, forms, etc., an officer of ordinary intelligence would soon acquire the necessary knowledge. By the choice at 20—22 years for civil or military promotion, a senior man from civil will be able to acquire the necessary military medical knowledge before passing to the administrative posts. Last sentence "we should make it....." This is hopeless. No man is going to come into civil if in addition to ordinary moves he is frequently changed back into military. Besides it is quite unnecessary.

In future the military side of the service is bound to be much the greater; there will be large numbers of officers in permanent military employ, who will be available to man the field ambulances at the outset.

Those called up will take the place of those who have gone or will fill up any vacancies in the hospitals in the field or at base. Besides large number of those in civil employ will be comparatively fresh from military and all will have had a proper military training which Indian Medical Service officers heretofore have never had owing to the regimental system.

A simple method of keeping into civil Indian Medical Service officer in touch with medical military matters would be to recognise a course of study at Home in the Royal Army Medical Corps college, Aldershot, as qualifying for accelerated promotion.

Paragraph 18.—Leave must be regarded as a part of the contract of service and not as a kindness.

Paragraph 19.—Yes. Entirely essential.

Paragraph 20.—In civil, seconded officers must be given their choice of presidencies as at present, according to their place on the list at entrance.

Paragraph 21.—The private practitioner requires no fostering. They have got most of the practice everywhere. For this reason civil medical men must be well paid, whether they be European or Indian.

Paragraph 22.—Yes. I think every one would agree but the question is how are you to get Indian Medical Service officers to be content to remain in every civil headquarters. The practice is in the hands of the private practitioner there and unless the Indian Medical Service officer has something to induce him to stay he will return to military.

Under the new "Reforms" the Government medical officer may not even be in charge of the local hospital or of any medical work in the district.

Is a European medical officer going to sit in Nadia for instance, without practice, without a hospital, without any thing to do except look after the police, local jail, and the wives of a few European officials?

Paragraph 23.—As it stands.

Paragraph 24.—Make it complete as soon as possible. Give the Royal Army Medical Corps every chance of volunteering to transfer to the Indian Medical Service, and make the terms of the service sufficiently attractive to secure the pick of the Universities and the best of the Royal Army Medical Corps. Stop the cheese-paring policy and the continual subjecting of the service to pin-pricks and rules devised to increase the work, lower the pay and allowances, and to cut down the opportunities of private practice. Let the medical budget be a liberal one and do not try to train officers from the day they arrive in India to live on the very minimum possible for themselves personally, and to carry on their work at the very smallest level of expenditure. Men brought up in this way, as has been the case hitherto, do not know how to face an emergency. They do not know the value that can be got out of money when it is necessary to spend and they feel helpless and lost.

The result is extravagance, as many unnecessary things are ordered; whereas, if trained in properly equipped hospitals they would know exactly what was required and would prove themselves to be efficient without being extravagant.

The Indian Medical Service hitherto has been starved in every way, under-staffed, under-paid, under-trained in military medical matters.

It has consistently been starved for money both in civil and military. Considering that more could be done for the health and happiness of the people by means of medical science than probably is possible under every other head of expenditure it is urgently necessary that more liberal ideas should permeate throughout the country and that means should be adopted to bring health and contentment to the people.

The epidemic diseases particularly require study and investigation and there are dozens of diseases to be prevented and that could be prevented if means were taken to do so. It is a question of money to a very large extent.

3 March 1919.]

The Hon'ble Major-General W. H. B. ROBINSON.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

MAJOR-GENERAL ROBINSON, called and examined.

The Bengal Government had given up to the following numbers of medical officers and subordinates during the recent war:—

Indian Medical Service officers 42, out of a total of 57.

Military assistant surgeons 28, out of a total of 34.
Permanent civil assistant surgeons 20, out of a total of 140.

Temporary civil assistant surgeons 20, out of a total of 50.

Sub-assistant surgeons 104, out of a total of 302.

The regular cadre provided for 12 Indian Medical Service officers for the district hospitals, and at the time when war broke out about 10 hospitals were in charge of Indian Medical Service officers; the bulk of the Indian Medical Service belonging to the province were employed in Calcutta. There were 24 districts in Bengal so that nearly half of them could have Indian Medical Service officers. Some were in charge of military and some in charge of civil assistant surgeons promoted to be civil surgeons while some were under uncovenanted men, a system which was dying out. The Indian Medical Service officers withdrawn from the districts had not been replaced. Their places had been taken by the senior civil assistant surgeons. No independent medical practitioners had, however, been employed for this purpose. There was one who was holding charge of a civil surgeoncy in addition to his duties as a railway medical officer.

The district hospitals in Bengal were under the local boards. This system had recently been changed in Dacca, where the district hospital was now no longer under the district board.

Before the war the leave reserve was 20 per cent. of the total strength of the Indian Medical Service which was quite inadequate. It should be raised to 30 per cent. The existing strength made no provision for study leave, nor for officiating vacancies and as a result leave was much behind hand.

A large number of the Indian Medical Service officers belonging to the province were employed in Calcutta. Most of them were professors of the Medical College and some were employed in the Presidency General Hospital. Eight out of 10 professors in the Medical College were Indian Medical Service officers.

During the war none of the regular professors except Lieutenant-Colonel Stevens, professor of surgery, had been allowed to go to military duty and the chemical examiner had been surrendered. His appointment was one which could be held by either an Indian or an Indian Medical Service officer. The professor of biology had also been surrendered to the army. When the chemical examiner proceeded to military duty, Dr. Chuni Lal, the senior assistant professor, had taken his place. When the professor of biology went, his place had been taken up by an outsider, who was not an independent medical practitioner but really belonged to the Indian Educational Department.

In the districts there had been a steady disintegration and deterioration in the general medical work during the war on account of the withdrawal of officers. There had been a distinct falling off in the surgical work, though the actual number of cases had been kept up, but the quality of work had gone down. There was a general lack of smartness and discipline in the hospitals. The persons placed in charge tried to do their best. The Inspector General of Jails complained very much; and so did the judicial officers, in connection with the medico-legal work.

The civil surgeon was in charge of the hospital and of the jail at every station.

The appointment of Sanitary Commissioner was one for the Indian Medical Service, but since the beginning of the war it had not been held by a member of the service. It was originally held by Lieutenant-Colonel Clemesha, who was transferred to Simla, and then by Major Fry for a short time. The present Sanitary Commissioner originally belonged to the Tea Planters' Association and was brought to Bengal as an expert in malaria. He had then been appointed as Sanitary Commissioner provisionally. All the deputy sanitary commissioners had also been taken away with the result that there was no Indian Medical Service officer left in the Sanitary Department. There were probably not more than 50 in the whole province the bulk of them about 20 being in and about Calcutta, the rest in the districts under railway and mines boards or as missionaries. Their services were not utilised to any great extent in the war. The present Port Health Officer at Calcutta was an independent practitioner before the war broke out.

The number of Indian practitioners was largely increasing. The number turned out by the colleges was growing every year about 100 graduating annually from the Medical College. This number would rise to 130 next year. There was a great demand for admission to the college, the number of students at present being 1040.

These medical practitioners were able to make their livelihood. He admitted that the remark that a majority of the members of the legal profession could make but a poor living applied equally to medical practitioners. It was possible to get an assistant surgeon on Rs. 100 a month. They had, however, improved in quality, as they were better trained than before. Their practical work was improving and the students before admission to the college were better educated than formerly.

The civil surgeon in a district had to attend to the officers in the station and to look after the jail. It might happen in the future that the district boards would prefer to appoint other than a Government medical officer to be in charge of the district hospital. Non-official chairman of the district boards were now appointed and in time this might lead to the demand for non-official medical officers in charge of district hospitals.

He had spent nearly 11 years in military service. He was of opinion that if an independent civil medical service having nothing to do with the military were started, it would be looked down upon as an inferior service. It would not be a good thing to have an independent military service like the Royal Army Medical Corps for the whole army in India, including the British and Indian army, independent of the civil medical service.

He was not in favour of substituting for the present war reserve of the Indian Medical Service a reserve composed of civilian practitioners who underwent a short military training. He did not see how it could be managed.

The charge of district jails should be held by medical officers. He did not think it would be in the interests of the jails that they should be in charge of non-medical men.

(General Cree.) There should be no difficulty in promoting an officer who was a specialist to superior rank in the army without compelling him to give up the specialist work on which he was engaged in order to hold some administrative office. All that would be necessary was that such men should be granted the administrative officer's extra pension. He approved of the suggestion that a specialist should not revert to the army and be put on administrative duty when he became colonel or general, but should remain on special duty without loss of promotion. If an officer was kept as a colonel for say 4 years he ought to be given the extra pension.

(General Hehir.) The remark in his written statement that most of the Indian Medical Service officers in civil had hardly averaged 3 years furlough in 30 years service was based on the statement of many officers who had been personally affected and represented the true state of affairs.

Study leave should be termed "study duty" and should be treated as such and made compulsory.

3 March 1919.]

The Hon'ble Major-General W. H. B. ROBINSON.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

The leave question had been one of the greatest grievances of the Indian Medical Service.

The students of the assistant surgeon class might be granted scholarships at the end of three years course for study in England. The number of Anglo-Indian students would be very small.

The conditions of service on both the civil and military sides should be improved, if it was desired that the two services should work together. Their pay should also be raised. Another important point was the necessity of granting officers free passages Home at stated intervals.

The number of residuary appointments should be kept as low as possible, selected appointments only being included in this category. There might be 15 such appointments in Bengal, namely the following:—The 8 major professorships in the Medical College, the Superintendents of the Presidency General Hospital (for Europeans), the Campbell Medical School and the Dacca General Hospital and medical school, one lunacy specialist and three administrative appointments, namely the Surgeon-General with the Government of Bengal, the Inspector General of Prisons and the Sanitary Commissioner.

The educational standard of the students who joined the Medical College was quite good, and sufficient to enable them to follow the course of instruction.

The ordinary independent civil medical practitioner could usefully be employed to serve the purpose of a second reserve, to be employed on civil duties in case assistant surgeons and sub-assistant surgeons were withdrawn for military duty. A large number of practitioners would be available to join a war reserve of this nature.

It would not affect the recruitment of assistant and sub-assistant surgeons, if joining the war reserve was made one of their conditions of service.

They should not be required to remain on military duty after 5 years' service by which time they would have got private practice, etc.

If the Indian Medical Service cadre were increased it would necessarily mean that more appointments in civil would have to be provided for them. These can easily be found. The Medical College alone could provide for 8 more appointments, and the Sanitary Department was in need of a number of officers.

The Indian Medical Service had very bad reputation at Home now-a-days and even if the prospects were improved they would not very much affect recruitment for sometime to come.

The local medical practitioners could not take the place of professors of medical colleges and could not perform such duties as efficiently as the Indian Medical Service officers.

(General Hendley.) With regard to the question whether assistant surgeons kept up their professional knowledge he remarked that some of them were very keen about post-graduate courses. There were the septennial examinations also, which led them to keep up their studies. On the whole he was of opinion that these persons kept their professional knowledge up-to-date.

The sub-assistant surgeons had no great cause of complaint, and their grievances were not well founded. Their designation was a suitable one and he could not think of a better. It would be rather an inconvenient and cumbrous arrangement to amalgamate the two services of assistant and sub-assistant surgeons putting the latter in the lower-grades calling one the "Graduate" and the other the "Non-Graduate class."

(Sir T. Nariman.) He was not in favour of simultaneous examinations for Indians with only Indian qualifications, as they had no training in special subjects particularly midwifery. This remark was based on his experience of Bengal and Northern India only as he knew very little about the other presidencies. It may be that in Bombay the students could get a chance of attending confinement cases, and had opportunities

of getting practical training in midwifery; but this was not so in Bengal. If the system of simultaneous examinations were introduced it would be essential to send the candidates for two years to England for training after they had passed the examination in India but that would have the effect of prolonging the period of study. The deficient knowledge of the practitioners was not in any way due to want of training in the colleges, but was mainly due to the want of cases. The poorest women even in the hospitals strongly objected to the medical students attending on them during their confinement.

In his statement about the lack of private practice among Indian Medical Service officers and when he said that the average income from this source for the whole service was about Rs. 200 a month, he was referring to the mufassil districts. These remarks did not apply to the presidency towns.

(Colonel Shairp.) He went on field service from civil duty when he had been nearly 18 years in civil employ. A very large number of senior officers went difficulty in getting into touch with the military direct from civil to field service. He did not find any administration and things went on quite smoothly. It did not take long for such men to become acquainted with military matters.

(Colonel Bhola Nauth.) European ladies objected to being treated by Indian doctors and Indian ladies objected to be treated by male doctors. This being so no doubt the teaching of midwifery to Indian students would not serve a very useful purpose, but midwifery being an important subject it would not be well to ignore it. Indian medical officers might be put in charge of stations civil or military and have to look after confinement cases. No doubt the actual demands on the Indian male doctors for a knowledge of midwifery were likely to be very small but it was essential that a doctor should be fully qualified in this branch of his profession.

The main cause which contributed to the decline in the private practice of Indian Medical Service officers was the increase in the number of Indian private practitioners. Besides, Indians naturally preferred Indian doctors to whom they could explain their cases and who could understand them better. In the old days there was only the civil surgeon to look to in a district town, but now-a-days there were five or six Indian practitioners besides the civil surgeon at each district headquarters.

The independent medical practitioners were not capable of holding the major professorships in the medical College. Indian practitioners were, however running the Belgachia College which was not yet affiliated to the University for the final M. B.

(Mr. Hignell.) There was great room for expansion in the case of the superior professorial staff of the Medical College. The professors had to teach a very much larger number of students than they should. The professor of physiology for instance, had a class three times as large as he should have. The number of students in the clinical classes ran to about 80 to 90, which was trying to the students as well as to the patients. More men were also required for special subjects and for sanitary work. In fact there was room for expansion in all directions.

(General Giffard.) There was great trouble about the leave question and officers had practically to wait till they fell ill. It was a fact that leave had been denied during the last thirty years on account of the Burma, Frontier and China war, and other expeditions, and on account of famine and plague. No compensation had been made for loss of leave in the way of extra allowance. In the case of famine however, they were allowed a month's privilege leave if they could get it. This was one of the grievances which had greatly affected the popularity of the service.

4 March 1919.]

Dr. W. W. KENNEDY.

*(The schemes and questions referred to by witnesses are contained in Volume III.)***At Calcutta, Tuesday, 4th March 1919.**

PRESENT:

THE HON'BLE SIR VERNEY LOVETT, K.C.S.I., I.C.S. (President).

MAJOR-GENERAL G. CREE, C.B., C.M.G., A.M.S.

MAJOR-GENERAL P. HEHIR, C.B., C.M.G., C.I.E., I.M.S.

MAJOR-GENERAL H. HENDLEY, K.H.S., I.M.S.

THE HON'BLE MAJOR-GENERAL G. G. GIFFARD, C.S.I., I.M.S.

and, as co-opted members, SIR T. NARIMAN, Kt. and LIEUTENANT-COLONEL BHOLA NAUTH, C.I.E., I.M.S.

S. R. HIGNELL, Esq., C.I.E., I.C.S.

LIEUTENANT-COLONEL A. SHAIRP, C.M.G., Indian Army.

MAJOR M. T. CRAMER-ROBERTS, D.S.O., Indian Army.

MAJOR A. A. MCNEIGHT, I.M.S. (Secretary).

Dr. W. W. KENNEDY, Calcutta, called and examined.

(President.) The witness said that he had been practising in Calcutta as a private medical practitioner for the last 16 years. Before that he had practised at Home for about 11 years. He had done sufficiently well in Calcutta, though he had not been able to save much. His practice was almost entirely among Europeans. It was only occasionally he had an Indian patient; but now and again Indian practitioners used to consult him.

In Calcutta, there were about six or seven European private medical practitioners of the same standing as himself. Of these, Dr. H. Brown, who had recently retired from the Indian Medical Service and taken up private practice, was the only one who was making much money. That was principally because he had a large practice among wealthy Indians which other European doctors did not enjoy. The practice of European doctors among Indians had fallen off greatly of recent years. Probably this was due to the growth of the Indian private practitioners. Some of the more prominent Indian doctors had already a considerable practice among Europeans, chiefly of the commercial class as opposed to Government officers and merchants. Indian private practitioners were increasing year by year.

He was not offered any post under Government during the war. He had never lectured at the medical school or college, but at one time he had been an examiner in hygiene. He had found that the students' knowledge was more of a textbook than of a practical nature.

He had found it difficult to appreciate the 4 schemes sent to him, owing to his having no connection with Government service, but of the four, scheme B seemed to him to be the one most applicable.

As regards private practitioners finding a place in the war reserve, he was of opinion that it would not be possible for any private practitioner to go out of the station for a month at a time for military training but suggested that they should be given an opportunity of doing part time work in station hospitals in Calcutta. European doctors would have no objection to such a scheme, nor would the younger Indian practitioners. He considered that such part time work should be paid for. In his opinion the Indian independent medical profession did not require fostering but Indian doctors who have established themselves in practice for three or four years would not be willing to give it up for military duty and could not therefore be relied on to form a war reserve. Besides this, most Indian doctors after a few years' practice in India became physically unfit through diabetes.

The witness and all other European doctors in Calcutta had been working in connexion with the Indian Defence Force, without pay.

As a private practitioner he did not think that specialists, professors, health officers or bacteriologists need necessarily be recruited as Indian Medical Service officers. They might be engaged at Home for five years as was done in the case of other branches of science. It ought to be possible to recruit on these terms. This proposal was not made with the object of depriving the Indian Medical Service of these prize posts.

In times of stress appointments in the service cadre should be made locally. Only properly qualified men should be appointed. The age of entrance could conveniently be raised above 26 years, the only thing to be insisted upon being that the candidates should be physically and otherwise suitable for the appointments. If the service were to be greatly expanded in the near future, he would advocate the raising of the age limit, in order to admit doctors who had served during the recent war.

The total number of European private practitioners in India was small. Railways, tea-gardens and coalfields had a certain number of independent practitioners, but it would be very difficult to bring these men together to a centre for military training. Apart from these difficulties, the European practitioners would always be perfectly willing to take their share in any war work. The only real difficulty was leaving the practice for a month. In the case of partnership concerns, it would not be so difficult.

European women and children in India require European medical aid. From his experience he could say that there were very few Indian doctors who were acceptable to European ladies and these were quite exceptional men.

(General Hehir.) He was in the Indian Defence Force. He helped them in the examination of recruits. The European practitioners of Calcutta were not capable of teaching in the medical college, except perhaps in medicine and surgery. Nor could they carry on research.

(Mr. Hignell.) At present medical practitioners could get all the facilities they would desire for visiting Government hospitals and institutions. The persons in charge of Government schools and hospitals had always been kind and courteous. Personally he would have liked very much some years ago to be appointed to a professorship or lectureship at the University. He had considered himself quite capable for it.

(General Giffard.) He had not thought of the difficulty or the expense connected with the provision of a reserve for leave and sickness in the event of private practitioners being employed as teachers and professors in medical schools and colleges.

4 March 1919.]

Dr. C. C. BOSE.

(The schemes and questions referred to by witnesses are contained in Volume III.)

DR. C. C. BOSE, M.B., M.CH. (Edin.), Chief Medical Officer, Eastern Bengal Railway.

Copy of a letter, dated the 28th February 1919, to the Secretary, Medical Services Committee.

With reference to your no. 10-10 of 15th instant, received on the 24th, on my return from tour, forwarding copies of four schemes which have been suggested for the re-organization of the medical service in India, I have the honour to state that it is not possible to review at length such an elaborate scheme within the brief time at my disposal, and I am only touching on the points that have come within my own knowledge. Evidence will no doubt be put forward by officers directly concerned, who will be in a better position than myself to give an opinion in the matter. The principal idea underlying the scheme for the unified military medical service for India, with a civil medical service as a reserve seems to have emanated from the trouble experienced during the war in securing an adequate supply of properly qualified medical men for military purposes and if this is so, I think it is most necessary that the civil medical departments and also unofficial medical practitioners should in future take a more important place in the military medical organizations in India, and the proposals put forward in the scheme seem to me to be all that is necessary to achieve this end.

Equality of conditions as regards pay, pension, etc., between the Indian Medical Corps (which includes the present Indian Medical Service) and the Royal Army Medical Corps would be an advantage as there is no reason why two classes of officers of practically the same educational and other qualifications should be treated differently.

If the conditions of service of military assistant surgeons is to be improved, their educational qualifications should also be improved. At present their professional knowledge is defective, and I would suggest that in future their course of training should be the same as the course of study for the civil assistant surgeons. Also post-graduate classes should be opened in all large centres where there are Universities, to enable both military and civil assistant surgeons and sub-assistant surgeons to keep up-to-date. This would also be a great boon to private practitioners.

Scholarships should be provided to enable those who are deserving of both classes (military and civil) to have a course of training in Europe.

I have noticed in the course of many years that, as things are at present, the professional knowledge of civil assistant surgeons is better than the professional knowledge of the majority of the military assistant surgeons. Military assistant surgeons who already possess European qualifications should be permitted to join the unified service as officers, if eligible. Here in India, civil assistant surgeons and military assistant surgeons are working side by side, and civil assistant surgeons possessing European qualifications should also be given this advantage, especially if these men have volunteered for military service.

I should think the formation of a special war reserve from independent medical practitioners in India, civil assistant surgeons and civil sub-assistant surgeons, would be a great step in the right direction, also the establishment of an Indian Medical Corps College for military training in the special lines of professional work for officers of the Indian Medical Corps, Indian Medical Department and special reserve. Military training could be introduced gradually among the civil assistant surgeons and sub-assistant surgeons by enforcing military service at first for one year which might be gradually extended to five years. I think most of the civil assistant surgeons and sub-assistant surgeons would take kindly to the idea of military training for a certain number of years, especially if better pay and pension depended on a course of military training.

A large staff of specialists in the army in India seem a necessity especially for post-graduate classes. The value of leave for study would be great and this I think is a move in the right direction, both for the benefit of the medical practitioners as well as of the public at large. Compulsory study leave in Europe for twelve months during service should be granted both to civil as well as military assistant surgeons.

DR. BOSE, called and examined.

(President.) He came out from Edinburgh 28 years ago. He had entered the uncovenanted medical service. He was appointed as civil surgeon of Goalundo and Kushtia in addition to being the Chief Medical Officer of the Eastern Bengal Railway. As he could not be confirmed in his former appointment he was recommended for the appointment of Chief Medical Officer of the Eastern Bengal Railway by the Agent. He has been employed as such for the past 28 years.

He had nothing further to say beyond what he had already submitted in his written statement.

He was in favour of an Indian Medical Corps for military training. It would be a good thing if independent private practitioners gave up their practice for a short time in order to undergo a course of military training. He thought they ought to sacrifice something.

(General Hehir.) He did not compete for the Indian Medical Service on account of the loss of one of his legs.

(General Hendley.) The personnel of his railway consisted of the Chief Medical Officer, an assistant surgeon and a sub-assistant surgeon. Sanitary inspectors are kept in large stations to see to the sanitary work.

SUB-ASSISTANT SURGEON SATKARI GANGULI, President, Bengal Branch, All-India Sub-Assistant Surgeons' Association.

- Written statement.

Answers to questions for military and civil sub-assistant surgeons formulated by the Medical Services Committee in serial order.

1. No. The rank "Warrant Officer" is meaningless in the Indian Army, carries no advantage at all, and does not command respect, its significance not being understood by the combatants and non-combatants alike. It sometimes happens that before a sub-assistant surgeon attains the commissioned rank, a sepoy who was inferior to him, gets into the commissioned rank and thus becomes entitled to

"salute" from the former, and consequently a feeling of irritation is created. This feeling is likely to be further accentuated if in spite of the higher initial pay under the revised and improved general and professional education he is still doomed to occupy an undefined position.

2. Yes certainly—in the existing medical colleges, nothing being yet known about the proposed military medical college to be established in India. If, however, the proposed college is well staffed for adequate professional training in all subjects connected

4 March 1919.]

Civil Sub-Assistant Surgeon SATKARI GANGULI.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

with their duties and profession, the military sub-assistant surgeons may be taken in there.

3. From the military sub-assistant surgeons' standpoint the proposal may prove to be inviting, and the commingling may engender better understanding to some extent between the two services. But to be fair to the civil members there should be an increase of posts under local governments and the educational qualifications of the two branches should be placed on a uniform standard.

4. Yes. A good secondary education is the foundation of all medical education, and the matriculation examination of every recognised Indian University or any examination which a University regards as a good substitute for it must be taken as a minimum educational qualification for admission into a medical school. The initial educational qualification for admission into the medical schools of a province in India must be the same both in the civil and military.

5. The demand of security deposit of money before commencement of training may prove to be quite unpopular, and stand in the way of recruitment.

6. The bond as it stands is sufficiently binding. There is a strong feeling that the binding should not extend beyond 5 years.

7. No. As the existing regulations make great differentiation between military assistant surgeons and sub-assistant surgeons as regards rank, pay, allowances and pensions although properly speaking there is practically no difference between these two branches in the matter of educational attainments, training and duties. Concessions should therefore be made to make the service attractive by placing them on equal footing with the military assistant surgeons in all respects and conferring on them the Indian commission irrespective of grade and length of service and fixing a time limit for service in military department.

8. Compulsory military training for all civil sub-assistant surgeons may not be popular and it may adversely affect recruitment. In my opinion a course of training is essential for the special war reserve recruited from the permanent cadre and from amongst the private practitioners. This training may, however, with advantage be introduced into the existing colleges and schools as an optional subject.

9. No. The existing regulations make no adequate provision for pensions for a military sub-assistant surgeon, his widow and dependents although a combatant and a military assistant surgeon are granted better privileges in these respects. The civil scale of pension too is inadequate, and there exists no provision as regards the maintenance of the widow and dependents of civil sub-assistant surgeon dying in the performance of risky epidemic duties.

10. Yes.

11. (i) *Medical education.*—The medical education in the existing schools at present is defective inasmuch as there is no uniformity in the matter of standard of general education prior to admission into medical schools as referred to in paragraph 4, no uniformity in training and coaching and equipments. Consequently there is no uniformity of professional attainments amongst sub-assistant surgeons. The standard of training should also be raised. For the deserving and ambitious products of the medical schools the conditions of admission into the medical colleges should be liberal and elastic with a view to prevent stagnation of intellect, and to encourage flow of students to schools. This may materially help in adding to the number of qualified medical practitioners, and also facilitate recruitment.

The curriculum of studies in schools should be so modified as to make the training recognisable by the General Medical Council of the United Kingdom. The present four years' course of training may be supplemented by an additional year's private practice and post-graduate training in a recognised college in order to make a fully qualified medical practitioner,

which should be recognised as a registrable qualification under the British Medical Act as in the case of the Society of Apothecaries.

(ii) "Once a sub-assistant surgeon, always a sub-assistant surgeon"—the policy in vogue is detrimental to the interests of the profession in general and the service in particular, and exercises a numbing influence over the class—in the military there should be one subordinate grade only, and this should be designated as military assistant surgeon, and in the civil the assistant surgeons' service should be filled in by competitive examination open to all University graduates and licentiates of medical schools, when the necessary conditions of training outlined above are fulfilled.

(iii) In the civil a sub-assistant surgeon is privileged to treat patients under all circumstances and in every appointment, but in the military the position is quite different, and the military sub-assistant surgeon is treated as a medical clerk, and he is not authorised to treat his patients independent of the medical officer, nor is he supposed to do any responsible work. This anomalous situation claims serious attention, as it places the branch of our service in a very ludicrous position.

(iv) Both in the civil and military the pay is inadequate as the rise in the price of all commodities in India have halved the income of the service whilst additional work and duties are always being thrown upon the services.

(v) Both in the civil and military the question of travelling allowance is of paramount importance, as since the privilege of form "E" in the military has been discontinued the trouble has commenced, as the issue of railway warrant hardly meets the actual expenses. The sub-assistant surgeon in a civil appointment should be treated as a 2nd-class officer with attendant privileges, and "E" form for the military should be renewed.

(vi) Free rations should be allowed to the military sub-assistant surgeons as in the case of the combatants, as the former has to work with the sepoys in the firing line.

(vii) "The hideous designation of sub-assistant surgeon" should be abolished, and a better substitute sought for.

(viii) The jail service is a matter of great concern to the civil members of the services as the sub-assistant surgeon is placed under the jailer, and there is no special attraction on account of inadequate emoluments and various other disabilities.

(ix) Family quarters are decidedly poor in the majority of cases, and the house-rent and compensation allowed for inferior quarters are inadequate. Even for the civil there is no provision for compensation for inferior quarters as in the military. I respectfully beg to invite the serious attention of the Committee in this direction.

(x) The School of Tropical Medicine should be accessible to the sub-assistant surgeon and the members of all class should be eligible for appointment in the Sanitary Department after a course of training, as health officers.

(xi) For the subsidiary jails, the sub-assistant surgeon who is designated as deputy superintendent, should exercise the control of the sub-jail as superintendent, as in case of the district civil surgeons.

12. Recruiting by open competitive examination either by the university, or properly constituted board for higher grades of service. The scale of stipends to the pupils should be increased.

13. Yes, by personal experience. My observation in paragraph 1 applies in this case also.

14. No one will object to being brought under the Army Act provided all the advantages enjoyed by military assistant surgeons, including commissioned rank in the Indian section are extended to the branch of our service.

15. Any such hard and fast condition may possibly retard recruitment. The obligation may advantage-

4 March 1919.]

Civil Sub-Assistant Surgeon SATKARI GANGULI.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

ously be inflicted upon those who are taken in a special war reserve or volunteer for military service. The less the civil side is interfered with the better as such interference may arouse confusion, and discourage the best elements of the schools to come for-

ward for service. Liberal terms of appointment held out to the candidates, coupled with a proper acquaintance with the nature of duties and the condition of service will naturally attract the people to join the service during eventualities voluntarily.

SUB-ASSISTANT SURGEON GANGULI, called and examined.

(Mr. Hignell.) He represented the views of the Bengal Branch of the All-India Sub-Assistant Surgeons' Association. He had 17 years service in all—14 in civil and 3 in military.

He was very dissatisfied with the present designation "Sub-Assistant Surgeon." He did not like the prefix "Sub," because strictly speaking they were not placed under Assistant Surgeons. He suggested that in future they should be called "Assistant Medical Officers" or "deputy medical officers."

Study leave should be granted to the extent of 12 months in the total period of service, and might be taken in instalments.

The starting pay of Rs. 30 which prevailed in some provinces was quite inadequate. Even the minimum pay of Rs. 50 for civil and Rs. 60 for military is not sufficient under existing conditions.

He considered that family quarters where they were provided were inadequate and that allowances in lieu of quarters were insufficient. He pointed out the absence of compensation for inadequate house accommodation in the case of civil sub-assistant surgeons.

The military allowance of Rs. 37-10 for the purchase of an outfit was quite inadequate. Civil assistant surgeons on the other hand received no allowances whatever.

The differential treatment between military and civil sub-assistant surgeons in the matter of family pension was a cause of dissatisfaction and discontent.

The field batta granted on field service was insufficient, and should be increased. The subcharge allowances granted were also quite inadequate.

He brought to the notice of the Committee the irregularity of a military assistant surgeon being in charge of an Indian War Hospital.

The present travelling allowances for military sub-assistant surgeons were inadequate. He was in favour of having form "E" introduced. He pointed out the inadequacy of travelling allowance

rates for civil sub-assistant surgeons also. They should get second class travelling allowance and an increased mileage rate.

He advocated the grant of furniture for family quarters.

The grant of "horse allowance" while in military employ was quite inadequate.

He considered that scholarships should be increased in the case of military students.

He did not think that the detention allowances given in military employ were adequate.

He suggested that the period for pension should be 20 and 25 years instead of 25 and 30 as at present.

He would like to have the same rank as Indian commissioned officers such as subadar, jemadar, etc.

He considered jail service very unpopular. The jail allowance was quite inadequate in comparison with the onerous duties of the post and lack of opportunities for private practice. Sub-assistant surgeons should be under the superintendent and not under the jailer as at present. The witness would have sub-assistant surgeons placed in executive and administrative charge of sub-jails.

He did not think education was uniform even in individual provinces. He was in favour of uniformity all over India. Medical schools should be uniform throughout India.

He was in favour of raising the standard of both general and professional education for sub-assistant surgeons. The period for training should be elastic to admit of further years for post-graduate training.

He considered that recruitment for sanitary appointments should be from assistant surgeons and sub-assistant surgeon and not from outsiders as at present. If the prospects were materially improved there would be no difficulty in getting sub-assistant surgeons to join the war reserve. If, on the other hand, Government made it a condition of service he feared a falling-off in recruitment.

5 March 1919.]

Civil Assistant Surgeon K. K. CHATTERJI.

*(The schemes and questions referred to by witnesses are contained in Volume III.)***At Calcutta, Wednesday, 5th March 1919.****PRESENT:**THE HON'BLE SIR VERNEY LOVETT, K.C.S.I., I.C.S. (*President*).

MAJOR-GENERAL G. CREE, C.B., C.M.G., A.M.S.

MAJOR-GENERAL P. HEHIR, C.B., C.M.G., C.I.E., I.M.S.

MAJOR-GENERAL H. HENDLEY, K.H.S., I.M.S.

THE HON'BLE MAJOR-GENERAL G. G. GIFFARD, C.S.I., I.M.S.

and, as co-opted members, SIR T. NARIMAN, Kt. and LIEUTENANT-COLONEL BHOLA NAUTH, C.I.E., I.M.S.

S. R. HIGNELL, Esq., C.I.E., I.C.S.

LIEUTENANT-COLONEL A. SHAIRP, C.M.G., Indian Army.

MAJOR M. T. CRAMER-ROBERTS, D.S.O., Indian Army.

MAJOR A. A. MCNEIGHT, I.M.S. (*Secretary*).

Dr. K. K. CHATTERJI, Representative of the Civil Assistant Surgeons, Bengal.

Written statement.

We have been realising that want of a spirit of enterprise with us (Bengalis) has stood in the way of our progress. Since the outbreak of the last war, Bengali youths have willingly volunteered for service in the Indian Medical Service, the Bengali Regiment, the University Corps, etc. I have submitted to the Government of Bengal a scheme for training ward orderlies for civil hospitals, and that scheme enforces a semi-military training. I have lately been formulating a scheme for compulsory military and ambulance training for medical students (Medical College, Campbell and Dacca Medical Schools) as a part of their course of study. I have been connected in some way with the Bengali Regiment and I recruited compounders for the station hospital, Alipore. I have also had sub-assistant surgeons working under me as resident medical officers who have been on military duty before. I have invariably found that these men have returned better men physically, morally and from the point of view of discipline, after they had undergone military training. Now that the Government has in view a scheme for unification of the medical services, and as it may involve the question of a special war reserve, I consider it an opportune time for us as assistant surgeons. I am prepared to serve with Indian troops and in Indian station hospitals and I presume that the scheme for unification of the medical services will in that case make provision for allowing me all the privileges of military service and granting me a military rank commensurate with my period of service as an assistant surgeon. It therefore necessarily follows that assistant surgeons should undergo a military training and under the above conditions they can be called to military employment. I do not think that adoption of these measures would be unpopular in our department nor do I think it would affect recruiting. I further think that difficulties in this line would be considerably minimised if my former suggestion, *viz.*, compulsory military and ambulance-drill-training, be adopted as a part of the course for the medical students in the medical college and medical schools.

Our existing pension rules are subject to improvement and I would suggest a graduated pension scale commencing, say, after the 16th year of service and terminating with the 30th year.

I state below some specific disabilities that exist in our service at present, but I hope that most of these will be removed when our service is merged into an unified medical service for India. (First.) The administrative status of our service is very low. We belong to the "subordinate medical department"

whereas other equivalent services belong to the "Provincial service." I can quote a specific instance. An assistant surgeon fairly senior in the service may be in charge of a sub-jail as deputy superintendent and as such he would be subordinate to a young sub-deputy collector who has just entered the provincial executive service. In my opinion members of our service when appointed to work as civil surgeons should invariably be superintendents of district jails and similarly in sub-divisions the assistant surgeon should be the superintendent of the sub-jail, the sub-divisional officer being allowed to exercise a similar control over the sub-jail as the district magistrate exercises over a district jail. (Second.) Our facilities for independent hospital practice, educational and research work, medico-legal and similar work are limited. These may be enlarged. For example we may be allowed to work in connection with the Indian research fund; assistant professors and other assistant surgeons with special qualifications may be allowed to officiate for professors, visiting physicians and surgeons of hospitals. More civil surgeoncies can be thrown open to deserving members of our service who have special qualifications. (Third.) According to our service conditions we are not allowed study leave. Such leave may be granted periodically for study in India and abroad and recognition may be made for those who have studied successfully and to the satisfaction of the Government. (Fourth.) The system of grade examination be abolished.

In my opinion some of the best class of young men are initially attracted to the civil assistant surgeon department, but I think that the conditions of service are such at present that many of these eventually leave the service. I am strongly of opinion that in altered circumstances many more would be attracted.

The present method of recruiting is in my opinion fairly satisfactory, but if an advisory board be appointed with the Surgeon-General with the Government of Bengal or the Principal of the Medical College as President, it might prove more satisfactory.

Military assistant surgeons as a class do not have as efficient preliminary or medical education as the civil assistant surgeons. Besides, they do not hold a qualification registrable in the United Kingdom. My strong impression is that throwing open civil appointments to the military assistant surgeons will be unpopular and it will be detrimental to our service. I venture to suggest that if civil assistant surgeons are to be kept as a war reserve the above measure will hardly be necessary.

5 March 1919.]

Civil Assistant Surgeon K. K. CHATTERJI.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

DR. K. K. CHATTERJI, called and examined.

(President.) The witness stated that the written statement which he submitted represented his views very clearly. He wanted the assistant surgeons to undergo military training and was also in favour of a unified medical service. He contended that the service to which he belonged had no administrative status. The facilities enjoyed by civil assistant surgeons in connexion with hospital practice, educational and research work, etc., were very limited. They might be allowed to officiate for professors and more surgeoncies might also be thrown open to the abler men of the service. Some of the best class of young medical men joined the service but a considerable number leave it in disgust after a few years and go into private practice or take up non-Government appointments. The present method of appointment was fairly satisfactory and there was always a great competition for assistant surgeons.

(General Hehir.) A war reserve could be formed from the ranks of civil assistant surgeons. Neither compulsion nor militarisation of the service would be necessary, if the conditions offered were good enough. Assistant surgeons being subordinate to the civil surgeons, they did not get as much free scope for hospital practice as they would otherwise get. In his opinion there should be facilities for those who wanted to carry out research, though he agreed that there could not be many interested in or anxious to do this class of work. He laid great stress on the necessity for compulsory study duty, and advocated the abolition of the grade examinations for promotion. They could always learn much more in practice than if they were to prepare for an examination. Moreover after a certain time, they could not study for an examination. Regarding military assistant surgeons, much of his objection would

be removed if the preliminary education and standard were raised.

(General Hendley.) There was no objection to having an examination at the end of the study period. If the candidate failed to get through that examination, he did not deserve promotion. Assistant surgeons should be compelled to be on military service or to form a war reserve only for the first 5 or 10 years. After that, it should not be compulsory but optional, as many of them became physically unfit; and the majority are by that time too much entangled in private practice and in family affairs to go to military duty.

(Mr. Hignell.) He joined the service in 1904. His pay was Rs. 220. He would have competed for the Indian Medical Service if he had had money to go to England. In fact he went to England later but then it was too late. He was advised by Sir Havelock Charles, his teacher, not to join the army for reasons best known to him.

(General Giffard.) Large numbers of medical graduates were being turned out year after year. Government could only employ about 20 or 30 additional men every year. If these men would go into the mufassil, they could always make a living. He himself had been to many places in the mufassil. His experience was that there was a great dearth of these men. At present the difficulty was that newly qualified doctors were congregating in and around Calcutta. In the mufassil they could make about 80 to 100 rupees a month, and the mufassil was a much cheaper place to live in. In his opinion, the raw men should not aspire to charge very high fees at first but begin with a small fee and then gradually to raise it as they establish themselves.

LIEUTENANT-COLONEL J. T. CALVERT, C.I.E., I.M.S., Principal, Medical College, Calcutta.

Written statement.

I do not think it possible to form one unified superior medical service for India, both for military and civil duties.

I do not think any of the proposed schemes can be carried out. Their point of view is too much from the military side, and does not sufficiently recognise the needs of the civil side, and the great changes now in progress and of the future which are taking place.

In the future there will probably be less Indian Medical officers employed on civil duties, and not more.

The Calcutta University Commission for instance suggested that the occupants of the professional posts in the medical college, as apart from the hospital, should be selected by the University, who would certainly not select Indian Medical Service officers.

As regards the military assistant surgeons, their career in civil life is practically ended. Their position none too secure, and being attacked before, was irrevocably damaged when the present students were ordered to be sent up for the License Examination of the State Medical Faculty, i.e., the same examination as that passed by the sub-assistant surgeons. They may be able to hold on to a few appointments, such as the assistant to the Principal at the Medical College, apothecaries to the Medical College, but all positions in charge as district civil surgeon or positions of authority over civil M. B. students, are gone beyond recall.

There are forces at work in Bengal and elsewhere, which are now beyond any control of the Secretary of State. These forces will act for at least one whole generation and probably much longer. I refer to the coming tidal wave of University medical graduates seeking employment, and which no demands of the

civil population can possibly meet for a long time to come.

There are 1,050 medical undergraduates at the Medical College which is full to overflowing. There are roughly 250 at the Belgachia Medical College recently instituted. As the latter now takes in 100 students annually, and the course is six years, there will soon be 600, and even this number will be greatly exceeded if the University permits it, so great is the rush into medicine on the part of young undergraduates seeking an avenue of employment. Nor will this flood cease until an absence of income from medical practice convinces the Indian public that the profession is overcrowded.

If an entrance examination for Indian Medical Service is held in India, Hindus will gain all the appointments. Mahomedans will ask for a certain number of appointments to be reserved for them. Beharis, Oriyas, Assamese and Burmese will all follow.

If scholarships are offered and education takes place at Home, some of the students from the backward classes might fail to qualify with consequent loss of money to Government.

You cannot expect these graduates (B. Sc., M. B.) who are older than the average medical students at Home, who are all married, and many of whom have several children, to go to England when they are 28-30 years of age and take up Home appointments and a second course of study.

The work of a civil surgeon in Bengal has trebled in my service of thirty years. It is now too complicated for any man to be able to take up for a few years and drop again; yet all the schemes suggest courses

5 March 1919.]

Lieutenant-Colonel J. T. CALVERT.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

of study to teach the officer his military duties, whilst he is supposed to learn his civil work by himself. Changes now take place so rapidly that even if a civil surgeon goes on long furlough he finds many changes which take him some time to learn on his return.

Provincial cadres must be maintained. It takes a long time to know the peculiarities, prejudices, etc., of the inhabitants of the various parts of one province—it would be hopeless to try and learn them of different provinces.

Indians entering an Indian Medical Service will demand absolute equality as regards pay, prospects and promotion. Any scheme, therefore, which fails to recognise this is foredoomed to failure. Any distinction on whatever grounds made will simply lead to constant friction and persistent agitation until it is removed.

Questions to be asked of officers regarding military assistant surgeons.

1. Where is this registrable qualification to be obtained in India? The only Indian qualification at present registrable in the United Kingdom is the M. B. degree of the various Indian Universities. To obtain this, means not one year's more study but two as an absolute minimum.

2. This does not arise—it is not in the power of Government under the present prevailing conditions to offer such facilities. No certificates of attendance at a medical school are recognised by the General Medical Council of the United Kingdom unless the student prior to undertaking such students has already been passed a preliminary examination recognised by the General Medical Council as entitling the holder to be placed on the students' register. Very few if any of the assistant surgeons prior to entering on their medical studies have passed such an examination. If they desire a British qualification they will first of all have to pass one of the recognised examinations as a preliminary to medical studies and then take a complete five years' course after this.

Presuming it is intended they should first obtain such preliminary qualification before joining the medi-

cal college, where are the Anglo-Indian schools capable of giving that education, and at what age will the boys obtain it and how are their fathers going to maintain them whilst they are obtaining it? The matriculation examination of the Indian Universities is no longer recognised as a preliminary qualification; the first science or first arts is so recognised, but this involves a two years' course of study after passing the matriculation examination.

I know of no Anglo-Indian schools apart from colleges capable of teaching students for the 1st B. Sc., which is the work of colleges affiliated to the various Universities. So far as I am aware the only preliminary examination these boys could pass in India, which would satisfy the General Medical Council, are the Senior Local Examinations of the Universities of Cambridge and Oxford, and even for these special regulations are issued showing the Council's requirements, which would have to be fully complied with by the teachers of the various Anglo-Indian schools, and might necessitate a change in their curriculum of studies to meet the necessities of these boys. Would they be willing to do this?

6. Not possible—so far from throwing open more civil appointments to military assistant surgeons it is practically certain the number will be seriously curtailed in the immediate future.

12. It does not attract the best men nor do I think it is ever likely to do so considering the better immediate prospects now offering.

14. The age of admission is far too low; these boys come here with a low standard of preliminary education, aged 16-17, too young and too poorly educated to take advantage of the educational facilities offered, they are left at the starting post by the older and better educated civil students, get disgusted and seek other avenues of employment.

Presuming you could arrange that the boys entered two to three years older, went through a five or six years' course, and obtained a registrable qualification, then on passing out they are going to be contented neither with their present pay and position or future prospects.

LIEUTENANT-COLONEL J. T. CALVERT, called and examined.

(President.) He did not think it was possible to form a unified superior medical service both for the military and the civil. He would let the Royal Army Medical Corps remain as they were and only improve the prospects of the Indian Medical Service, if possible.

In any scheme that is proposed present economical factors will have to be taken into consideration. The position had considerably altered since he joined the service.

When he entered the Indian Medical Service there were more qualified young men than could easily find employment. The surplus men without capital and ambitious men often came to India in those days, but now-a-days there was no need for them to leave Home.

In the old days in India there were more appointments than the students could fill whereas at the present time the supply was greater than the demand, and this was due in a great measure to the number of graduates that were being turned out from the Universities, who finding the profession of law filled up turn to medicine. The medical college was filled to overflowing with candidates and there was no likelihood of this rush stopping if the Universities turned out such large number of graduates. He had 800 boys qualified under the rules to enter the medical college and the normal annual admission to the Calcutta Medical College was 120. These 120 had to be selected, and this selection could not take place until the publication of the *Calcutta Gazette* as the statements of candidates have to be verified.

The selection was usually made from the highest qualified students, and these were men who had passed the First Arts, First Science, B. A. or B. Sc., etc.

Although Government raised the standard of qualification for entry into the medical college still the flow did not stop. There were many students with the B. Sc. degree who had no appointments and were willing to enter the Calcutta Medical College. A boy was usually 16 or 17 when he matriculated and by the time he obtained his B. Sc. he was 23. He could fill the medical college with B. Sc.'s. The students of the medical college were generally older than the boys in England. They simply enter on account of competition for employment and not from any special desire on their part to join the medical profession.

The opening of the Belgachi Medical College had in no way relieved the Calcutta Medical College. This was due to the demand for graduates in Arts and Science for work not keeping pace with the outturn from the Calcutta University with the result that Bachelors of Arts and Bachelors of Science could not find employment. He foresaw great difficulty from the fact that there would not be sufficient employment for the medical graduates that are being turned out every year. These young doctors are very often not even of the middle class; clerks and others of the same class put their sons into the medical college if they can find sufficient to pay the first year's fees, without any thought about the expense which must follow. Such students often get stranded after one year, and then deemed a scholarship or Government assistance. Numerous scholarships at the medical college are given now by the Governments of Assam, Bihar and Orissa, and Burma as well as by various district boards, etc.

The demand for treatment by western medical methods was undoubtedly increasing in the cities and

5 March 1919.]

Lieutenant-Colonel J. T. CALVERT.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

among the educated classes, but not very much in the mofussil, nor was the total increase in this demand at all in proportion to the number of graduate doctors being turned out.

In contrast to the excessive number of students at the medical college, the number of men with lower qualifications, that is, the licentiates, was short of the demand. He feared that nothing but the threats of starvation would induce the newly highly qualified doctor to leave Calcutta, and go to practise in the mofussil, as the fees paid for medical attendance are much higher in Calcutta than in the districts.

The work of civil surgeons in Bengal had increased enormously during the last 30 years. At his first civil station in India which was not a small one, his duties had comprised the charge of the hospital and jail, and attendance on the officials stationed there. Shortly afterwards he had been transferred as civil surgeon of Mymensingh, the population of which was 4 millions and the vaccination of that district was thrown on him, and all he could get out of Government was an almirah for the storage of records. In Mymensingh, district board and dispensaries were very soon started and before long he found that he was supposed to inspect and report on 30 such dispensaries every quarter. He found that if he carried out all this work he would hardly ever be at headquarters. In addition he had to inspect and report on 8 municipalities four times every year. The amount of medico-legal work had increased enormously and the civil surgeon was supposed to do all *post-mortem* examinations himself. The jail work likewise increased to a very great extent.

In fact the work had practically trebled on all sides while the pay had remained the same. He considered that it would be very unwise to abolish the system of provincial medical cadres. It was essential for a medical officer to know his province and to be familiar with the people and their customs and language, and also have some knowledge of law.

He was on the Committee of the Belgachia Medical College. It had just completed its third year. Government had given them Rs. 5 lakhs, and had promised them an annual grant of Rs. 50,000, if certain conditions were fulfilled.

(General Cree.) With regard to the possibility of re-constituting the Indian Medical Service on the lines of the present Royal Army Medical Corps witness stated that this would depend on what the attractions in civil were. Although military service might perhaps be made attractive, the main attraction of the Indian Medical Service had always been, and was now, the prospects held out by civil employment. There was going to be a less proportion of Europeans than at present under whatever conditions might be introduced. The service had been losing its popularity for years. Government never kept faith with the service as regards leave. A number of concessions and privileges had been withdrawn. Formerly fees were granted for certain duties; these were now possibly rightly so withdrawn and the duties had to be done for nothing. He would advocate an attempt to convert the Indian Medical Service into a real corps, but would not recommend the complete separation of the civil from the military sides. The present duality of employment was of great advantage. If an officer found that one side of the service did not suit him he could transfer to the other.

(General Hekir.) All the four schemes seemed to him to be devoted too much to a consideration of the military medical service, and to lose sight of the importance of the civil.

He was opposed to the compulsory reversion to military of officers in civil employ for six months' training, as the upset to their lives and professional work might adversely affect recruitment. For the same reasons he objected to the proposal to institute compulsory examinations in military subjects. If officers were given the choice of passing the examinations or of giving up all prospect of advancement to military administrative appointments, it would be less objectionable.

The position of military assistant surgeons was a difficult one. They were out of touch with all modern development. Formerly military assistant surgeons were given a diploma by the colleges in India. No one outside the service knew exactly what this diploma was worth. This had now been abolished.

As a reward for work in military they are sometimes put in charge of civil surgeoncies. If an occasion arose for them to give evidence in a medico-legal case the first question they were asked was, are you a registered medical practitioner? They usually got out of the difficulty by referring the questioner to Government.

He stated that only the previous day a representation from the civil assistant surgeon class had passed through his office asking for more pay, and suggesting that in future no medical officer who had not obtained a qualification registrable on the British Register should ever be put in charge of a civil district. This was aimed at the civil employment of military assistant surgeons. The age of admission into a medical college for these boys was very low. They came in at 16 or 17. Their preliminary qualifications were very poor, with the result that they found themselves lost and were unable to follow the lectures, etc. This state of affairs usually made them disgusted and they consequently began to seek employment elsewhere. It was a fatal blunder to have a military school in a big place like Calcutta. There were far too many temptations. A boy when he found that his prospects did not compare favourably with others resigned and left. He suggested that the military school should be in a military centre.

If the standard of education is raised the teaching in Anglo-Indian schools would also have to be raised. He was not aware of any Anglo-Indian Schools which were capable of teaching students for the 1st B. Sc. This was the work of a college. If the preliminary standard of education were raised it would necessitate the boys entering the College at a later age, with the result that the main attraction of the Indian Medical Department to the parents of poorer Anglo-Indians, *viz.*, the prospect of getting their sons off their hands at an early age, would be lost. Unless it was proposed to take in a better class of Anglo-Indians and after giving them a proper education with registrable qualifications to employ them in the place of Royal Army Medical Corps officers, it would not be possible to go on. Once they were given a registrable qualification they would not be content to serve as warrant officers in the Indian Medical Department. Their present work was that of a senior compounder. The civil side was going to be closed to them. He was of opinion that Anglo-Indian schools and boys were very much behind the times.

The age at which medical students in Calcutta graduate is rapidly rising. If such graduates are sent to Europe for further study before admission to the Indian Medical Service they will have passed the age limit before they can compete for the examination.

The proposal to give scholarships to passed third year students was unworkable. If they were given by open competition they would all be won by Hindus. Mahomedans and others would then complain and demand that a proportion should be reserved for them. If men of these classes were given scholarships by nomination and sent Home, they would possibly be unable to pass the Entrance examination.

The only sound method of admission to the Indian Medical Service was by open competitive examination held in London.

He considered that some of the Indian private practitioners were fitted to hold professorships at the medical college, except for their inability to maintain the necessary standards of discipline.

In reply to the question whether, in view of the small size of the provincial Indian Medical Service cadre, an alteration in the method of making professorial appointments in Calcutta was advisable, the witness thought that the time had arrived to throw open all professorial

5 March 1919.]

Lieutenant-Colonel J. T. CALVERT.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

appointments, not only in Calcutta, but also at Madras, Bombay, Lahore and Lucknow, to all Indian Medical Service officers.

He considered that officers who might hereafter be appointed to professorial appointments in Bengal should

be relieved of duties of a kind that were not ordinarily performed by professors in other provinces, and that they should be restricted to consulting practice, but that officers now holding these chairs should not be affected by the change.

DR. S. P. SARBADHIKARI, C.I.E., B.A., M.D., President, Bengal Medical Association. (*President, Medical Educational Society of Bengal (Belgachia Medical College), Fellow of the University of Calcutta, Member, Governing Body of the State Medical Faculty, Member, Bengal Council of Medical Registration.*)

Written statement.

I am submitting this statement as the representative of the Bengal Medical Association, for the consideration of Medical Services Committee, but regret to state that the short time available for examining the four schemes made the submission of detailed criticism and suggestions extremely difficult.

A study of the four schemes makes it clear that the adoption of any one of them without change will mean the virtual exclusion of members of the independent medical profession from the superior medical services of the country and relegation, even more marked than at present, to a subordinate position; and this at a time when that branch of the profession has reached a very high level of proficiency, and Reforms having for their object the conceding of the just rights of the people of the country are in the air. At such a time and in these circumstances it is suggested that whereas in the profession of law, engineering and teaching, Indians are considered fit and eligible for and are actually holding the very highest offices in the State, in the profession of medicine alone the brand of inferiority is to continue,—more accentuated than ever. This is a position which the country and the profession will never accept.

Schemes A, B and C are chiefly concerned with the unification of the Royal Army Medical Corps with the Indian Medical Service. From the purely military point of view probably all the schemes will be an advance upon existing arrangements, especially if the proportion of military medical officers in charge of Indian troops is raised from 1·2 per mille to 3 per mille. But they absolutely ignore the independent profession. Scheme D is a slight improvement. My Association would support scheme D provided that:—

- (a) the proposed Indian Army Medical Corps, *as such*, is dissociated from the civil medical service,
- (b) the proposed restrictions upon the entry of medical graduates of Indian Universities are not imposed,
- (c) simultaneous open competitive examinations are held in India and Great Britain for recruitment into the Indian Army Medical Corps, for which all candidates possessing qualifications registrable in Great Britain will be allowed to sit,
- (d) those who are successful in the open competitive examinations held in India undergo a further course of military medical training for one year in Great Britain,
- (e) for the subordinate service military assistant surgeons having the rank, pay and prospects of warrant officers, for service with Indian troops be created and recruited from Indians holding diplomas and licenses registrable in India.

The Association welcome the idea of developing the station hospital system and of the creation of a fully equipped and up to date Indian Army Medical College, similar to the Royal Army Medical Corps College at Millbank, to which military medical officers of all grades should proceed for medical study.

The Association consider that with the severance of Army Medical Service *as such* from the civil

medical department is bound up the growth and development of a healthy and vigorous medical profession and the best interests of the people in India and that no case whatsoever has been made out or for differing from the remarks of Sir M. B. Chaulal in his minute of dissent, *vide* page 282 of the Report of the Royal Public Services Commission.

In England civil appointments are not used as berths for seconded Royal Army Medical Corps men. The only substantial ground for grafting the Indian military medical service almost bodily on to the civil is to utilise the latter as a war reserve, on the supposition that in emergency the independent medical profession will fail to respond to the call of duty, or, if it did rise to the full height of the occasion, the want of previous training will discount its usefulness as a war reserve. The Association, which within twenty-four hours of the declaration of the war, voluntarily offered to His Excellency the Viceroy contingents of fully qualified medical men for service in all emergencies and had the proud privilege of being allowed to make good their offer are definitely in a position to say that there never was lack of a continuous stream of willing recruits for temporary Indian Medical Service work, whenever the demand was made. Indeed, the entire cadre of the permanent Indian Medical Service has been nearly duplicated by temporary officers from India and Great Britain who have now put in from one to four years' military service. The work done by these men, in all possible positions, my Association are able to say, has been spoken of, with few exceptions, in high terms by the highest authorities. A certain number of confirmations as permanent officers, in the case of Indian as well as British qualified temporary officers and the fact that in the past purely Indian qualified men have passed straight into the Indian Medical Service in incredibly short time after arrival in England (at the regular examinations) indicate that where these men came from there are many more. It is also definitely within the knowledge of my Association that given the chance, large numbers of these temporary officers will elect to remain in military service and would not revert to civil life. Here then is the material necessary for creating a sufficient war reserve. A scheme for drafting as much of this material into permanent military service as possible, to meet the increased demand when the proportion of officers for Indian troops is raised to 3 per mille, and giving "retaining fees," or, "bonuses" to the rest, and keeping them as part of the war reserve, as well as a well considered plan for training and keeping in training members of the civil medical service and such of the independent medical practitioners who desire it, should dispose of the fear of the absence of an ample war reserve for emergency such as that of 1914-19. In the light of recent experience that fear is illusory, as also the fear that the independent medical profession in India will not at least behave as well as that in Great Britain, where too, no medical war reserve worth the name exists. Indeed no other war reserve will suffice for contingencies such as that of 1914-18, or any greater ones that may come.

Civil Medical Service.

The Association are fully conscious of and desire to acknowledge the deep debt of gratitude which the country and the profession owe to the Indian Medical

5 March 1919.]

Dr. S. P. SARBADHIKARI.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

Service and to their predecessors in the Honourable East India Company's service, for the splendid pioneer work they have done in creating an independent medical profession in India which has now reached a very high level of efficiency. That profession has further received an accession of strength from numbers of men, Indians and Europeans, who have received their training abroad and hold all kinds of British degrees and diplomas. My Association voice the feeling of the entire independent medical profession in saying that the time has arrived when their great mission, well discharged, the Indian Medical Service, while continuing to be the guide, philosopher and friend of the honoured profession they have helped to create, should leave it to manage the civil medical affairs of this country and work out its own destiny. That will be in the best interests alike of medical administration and the rise of a still greater independent medical profession.

The first step towards that end is the severance of the Indian military medical service, as such, from work on the civil side of the profession. The tentative scheme for the reconstruction of the civil medical service which the Association desire to advance may be outlined as follows :—

The higher service.—This will consist of (i) deputy surgeons, with a pay of Rs. 300 rising to Rs. 600 by annual increments of Rs. 50. (ii) district surgeons, from Rs. 600 to Rs. 1,200 with annual increment of Rs. 50. Those recruited in England shall have a separation allowance of one-third of their pay.

These officers should be recruited by open competitive examination, held simultaneously in England and India. Candidates obtaining admission by the Indian examination shall undergo a further course of training in England for at least one year, before commencing their duties. A part of the time spent in England must be devoted to a course of military medical subjects at the Royal Army Medical College, Millbank. Those recruited directly in England should spend at least six months after passing the examination in learning the military medical subjects at the Royal Army Medical College in India and six months more in learning the vernacular language and in familiarising themselves with the habits and customs of the province where they are to be posted.

All these officers shall serve for the first seven years of their service as deputy surgeons holding charge of sub-divisions, or be attached to presidency hospitals, as junior staff and perform the duties now done by assistant surgeons.

At the end of the seventh year of their service these officers should go abroad on study leave, during which period they should be attached to some recognised hospital in the United Kingdom or elsewhere. After the completion of their further study and having produced evidence of having sufficiently profited by an approved course of post-graduate studies they will be considered eligible for holding charge as district surgeons.

The subordinate service.—Members of this service shall be called assistant surgeons. They shall be recruited from Indians and Anglo-Indians possessing any qualification registrable in India by open competitive examination in the various provinces of India and shall have a salary of Rs. 75 rising to Rs. 200 with an annual increment of Rs. 10. Officers of the senior grades of subordinate service, who possess qualifications registrable in Great Britain or whose services are approved may be promoted to the superior service by selection.

In order to make the officers of civil department efficient reservists for military duties they should have

periodical training, by rotation in some military medical college established in India or be deputed to undergo a training of not less than 6 months at a station-hospital or some other form of military training with troops.

Jail and sanitary appointments will be held by officers of the civil medical service.

The independent medical profession.—My Association beg to point out that the services of the independent branch of the medical profession have not thus far been properly utilised. Succeeding Secretaries of State for India recognised the unsoundness of the policy. My Association think that by obtaining the co-operation of these medical men the State will benefit pecuniarily and at the same time it will encourage the growth of an independent medical profession of the highest standard. My Association therefore beg to suggest that in the presidency hospitals and in the large district hospitals honorary appointments should be thrown open to private practitioners of proved merit and ability.

Medical education and research.—This should be a branch of the civil medical service, but should be an entirely distinct one from other branches. Recruitment to this service will be made by an Advisory Board serving under the Government of India, helped, when deemed desirable, by the advice of experts in Great Britain. In filling these posts the selection will be made from applicants in Great Britain and India, and on no account should be restricted to any particular service or section of the profession. My Association view with satisfaction the admission made by the author of scheme B that it is impossible for the local government to fill these appointments in a satisfactory manner from amongst that portion of the Indian Medical Service which for the time being happens to be in civil employ. My Association will go further and suggest that very often a suitable man to fill a professorial chair can not be found in the Indian Medical Service, because the main point in electing a professor is firstly, teaching experience and secondly research work. Simply to have passed the Indian Medical Service examination is no proof by itself that a man is fit for a teaching appointment. In the various Universities and Colleges in Great Britain and India, in all subjects, some men are working under the professors who would be quite capable of taking up the duties of professorship whenever opportunities are given to them. My Association will not prevent any one with the necessary qualifications for filling up an educational appointment, simply because he belonged to any service. In fact, service and non-service men should be given equal opportunities for filling up these posts, if they are fit. The above remarks will apply to scientific and research posts. My Association in suggesting a scale of pay for these posts, would only say that the pay must be generous enough to attract the best men of the profession and which would enable them to devote the greater portion of their lives to educational and research work without having recourse to private practice. £800 rising to 1,500 per annum is tentatively suggested. The posts should of course be pensionable.

In order to enable officers in the civil medical service or the educational service to obtain higher qualifications, study leave should be given on favourable terms.

Administration.—The Director of the civil medical services in each province shall be the head of the department and shall have the same rank and pay as the Surgeon-General or Inspector-General. Selection to this appointment must be made by an Advisory Board from the members of civil medical service.

DR. S. P. SARBADHIKARI, called and examined.

The witness was the president of the Belgachia Medical College society.

The college had been in existence for 31 years and had been affiliated to the Calcutta University for the

5 March 1919.]

Dr. S. P. SARBADHIKARI.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

last three years. It was the outcome of two institutions one of which was the medical school teaching up to the vernacular standard which was started 31 years ago. Two individuals were its leading spirits and with them were associated 9 or 10 other men and private practitioners of Calcutta. Soon after they founded this school it was apparent from the number of applications for admission, and the qualifications of the students who applied for admission, that there was sufficient demand for medical education not only of the school type, but also of the college type, among the people of the Presidency, and it was also apparent that even these comparatively insufficiently trained students who were being turned out were useful to the country. It was then considered that side by side with this school there was no need for an independent medical college. About the year 1891 what purported to be a college was started under the name of the College of Physicians and Surgeons of Bengal. The school and college were then separate institutions under different management, managed privately and manned and financed entirely by private practitioners helped by well-to-do Bengalis. The two institutions went on side by side for about 9 years till 1901. Then it became clear that, in order to satisfy the needs of a modern medical institution, divided effort would not do, and that the limited funds at the disposal of private persons were not sufficient. Under the advice and suggestion of several Indian Medical Service officers, chief among whom was the late Sir Pardey Lukis, a scheme of amalgamating the two institutions was evolved. It took three or four years for the managers of the two institutions to come to an understanding. The school and college then joined hands and both were run in the same premises for about 12 years. It was then found that the institution was too big, the students numbering about 700, for the limited resources at the disposal of the organisers. Under the advice of the late Sir Pardey Lukis they cut away the school portion and concentrated their efforts on collegiate study, and the good work they were able to show attracted the notice of Government which rendered great assistance in bringing the college up to the Calcutta University standard. The college was now affiliated to the University for teaching up to the intermediate standard and the question of getting it affiliated up to the final degree was under consideration.

Under the regulations the number of students which could be admitted in all the three years was limited to 300. A large number of students, about 500, had to be rejected every year. They took 150 students each year while there were about 700 applicants for these vacancies who possessed much higher qualifications than those laid down in the regulations, a large number being graduates. The number of applicants seeking admission was becoming greater and greater year by year.

He had been associated with the college for 29 years. Before the institution of the license by the State Medical Faculty in Bengal the avenues of employment to the persons turned out by the college were (1) chiefly private practice in the suburban and rural areas, while a few settled down in Calcutta, (2) appointment in tea, coal and mining industries, (3) service with local boards and with well-to-do zemindars who were able to afford family doctors. A large number got employment in this way but since the institution of the State Medical Faculty the number could not increase as the Medical Degrees Act recently passed made it incumbent on local boards, municipalities and factories, etc., to employ only those who had registrable qualifications.

Since the institution of the State Medical Faculty a large number of the boys from the college sat for an examination and got a license under the transitional provisions of that Act, but the greater proportion of them were still unregistered, as those who had more or less settled in life and had attained a fairly good practice naturally did not like to sit for an examination in which there might be a chance of

failure and for which they would have to study afresh. They were not debarred from practising and, as they had secured their practice and people had faith in them, they did not care to get a license.

The Kavirajis were holding their own against the doctors trained in western medicine. In Calcutta there were Kavirajis who charged as high and even higher fees than Indian Medical Service officers. Some of them were charging extraordinarily high fees up to Rs. 1,000 a day, both in Calcutta and the mufassil. There was at the same time a great demand for doctors. In fact there was plenty of room for both.

The doctors who were being turned out from the colleges could make a comfortable living. They could look forward to an average income of Rs. 300 to 400 a month after a period of about 3 or 4 years.

Though there were a large number of literates such as retired clerks who were living in the villages, the retired assistant surgeons did not settle down in the villages and generally resorted to the towns though they could not have much practice there as the field was fully occupied by other doctors who had already established practice. Besides, by the time they retired they had not enough enterprise left in them and they could not push forward against others who had made a reputation.

The military medical service should be dissociated from the civil medical service. The proportion of medical officers in charge of Indian troops should be raised to 3 per mille.

The Bengal Medical Association recommended that in the presidency hospitals and in the large district hospitals honorary appointments should be thrown open to private practitioners of proved merit and ability. The intention in making this recommendation was that private practitioners should be allowed to work and perform operations in these hospitals without any payment. They should be given some share of the work. The experiment had been tried in Calcutta on a small scale and had proved a success.

(General Hendley.) The assistant surgeons should be abolished as a class and their place should be taken by the present sub-assistant surgeons. The former should be raised to the position of deputy surgeons. With the improvement in the position and prospects of the new assistant surgeons he would be quite content to remain where he was. There had been one omission in the written statement to the effect that during the transitional period the assistant surgeons should remain *in statu quo ante*. In the future assistant surgeons of the present type would not be recruited.

He had suggested in his written statement that military assistant surgeons, with the rank, pay and prospects of warrant officers, should be recruited for service with Indian troops, from among Indians holding diplomas and licenses registrable in India. These men really belonged to what was called the sub-assistant surgeon class. Their position, pay and prospects were not attractive enough in comparison to the work they did. During the war Government had great trouble with these persons, but if the plan recommended above were followed service will be rendered much more attractive and the same class of men will join much more readily. The Indian commissioned rank of jemadar or subedar which they could at present look forward to was much less respected than British warrant rank. They should therefore be given British warrant rank. Their complaint was that military assistant surgeons with the same and even lesser qualifications were continually put over them.

Medical officers recruited in England should be given a separation allowance of one third of their pay. It need not be given to Indians and should be given only to pure Europeans.

Europeans will probably be prepared to come as deputy surgeons on the pay of Rs. 300—600 suggested in his written statement, plus the separation allowance of one third of the pay. They should remain in a subordinate position for 7 years. In

5 March 1919.]

Dr. S. P. SARBADHIKARI.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

addition to the pay and separation allowance they would have liberty for private practice. He did not see any objection to Europeans being placed in subordinate positions to start with.

The work at present done by assistant surgeons would, under the new scheme, have to be done by officers recruited for the proposed new service. No doubt it would be a much more expensive plan but it would at the same time be much more efficient. It was essential to pay more for having better work. The whole of the service would consist of Europeans as well as Indians.

The Association recommended that the best men of the profession in England should be recruited for professorial and research work on an annual pay of £800 to £1,500, plus a separation allowance of one-third of the pay. He believed that specialists would be willing to come on these terms as they went to Canada and Australia. They would not look only to the emoluments but to the vast opportunities they would have for research work in India. In case, however, the pay proposed was inadequate to attract really good men it should be raised. If this were done and India had the advantage of first class men devoted to teaching and research work a good deal of the difficulty about study leave would disappear.

(*Sir Temulji Nariman.*) The Belgachia college had been affiliated to the Calcutta University up to the Intermediate standard. The college was inspected by the University Inspector, the Surgeon General to the Government of Bengal, and one other competent medical officer.

It had applied for affiliation to the full degree, and having regard to the instruction at present given in midwifery, he did not think that there could be any objection to the grant of such affiliation. At present they did not take in more than 60 maternity cases but arrangements were being made with another hospital in Calcutta so that 150 to 200 maternity cases will be available for training purposes for the college. These would be sufficient for the 40 or 50 students coming in for the next four or five years. The maternity cases were not given to the students till the sixth year of their study.

With regard to the remark of one of the witnesses that Indian women objected to being examined and treated by male doctors, he admitted that this used to be more or less the case till a few years ago, but a great change had taken place during the last 10 years. He could say from personal knowledge that there were in Calcutta at least six Indian practitioners, with both European and Indian qualifications, who practised midwifery alone. Besides these, there were a few who, in addition to their ordinary medical work, attended midwifery cases. Apart from the middle class and poor houses, even in the high class families there was no opposition from Indian women to their being examined and treated entirely by male doctors, even without the intervention of a lady doctor or midwife. The want of such cases in the Eden Hospital would be explained by the existence of the Dufferin Hospital and the recent creation of a better class of lady doctors and midwives, and also on account of the facilities which Indian women now had of being treated at their homes by competent female doctors. Fewer people thus went and sought relief in the hospital if they could afford to get it at their homes. Lastly, though not a great factor, but still an appreciable factor was that the hours of attendance at the Eden Hospital had been changed and were now very inconvenient for women to come with their male relatives. In the Belgachia college they sought to overcome this difficulty by an arrangement for extra-hospital maternity attendance on patients. This had already been in force for some time and was attended with satisfactory results.

There were no insuperable difficulties in the way of holding simultaneous examinations in England and in India on the score of a practical test. There was enough material in the Presidency General Hospital where the practical test could be held. Senior pro-

fessors would be the fittest persons to conduct the test. In England even, there were different examiners to conduct the examination of different sets of students at different centres. It was not essential to have the same examiners and absolutely the same test for all the students in the competitive test.

(*Colonel Bhola Nauth.*) As explained in paragraph 2 of his written statement, the adoption of any one of the schemes will mean the virtual exclusion of members of the independent medical profession from the superior medical services of the country. All the schemes, with the exception of scheme D, had so arranged things that the service will be entirely European. The sub-assistant surgeons who would be promoted to the auxiliary corps were bound to be few and far between and might be termed a negligible quantity. The schemes went so far as to suggest that the present arrangement of treating the degrees granted by the Indian universities as qualifications registrable in Great Britain, should be done away with. The schemes thus aimed at the virtual exclusion of Indian practitioners.

He was of opinion that whoever had suggested that after a few years' practice Indian medical practitioners became unfit for work and began to suffer from diabetes had drawn purely upon his imagination. He admitted, however, that diabetes was more prevalent in Bengal than in other parts of the country.

There were a number of Indians possessing both Indian and British qualifications who could fill with credit professorial appointments and do research work.

There was no feeling on the part of the European ladies against being treated by Indian doctors. This feeling had been artificially engendered and fomented of late. There were at least half a dozen Indian doctors in Calcutta who every day of their life treated gynaecological and obstetric cases in the houses of Europeans of position. Not only did European ladies not object to being treated by Indian doctors but in many cases they would choose an Indian practitioner in preference to an Indian Medical Service officer. He could name some of the biggest people from the Lieutenant Governor downwards who would prefer to be attended by Indian doctors. During the recent war, when a number of Indian Medical Service officers had been withdrawn there had been no falling off in the number of European or Indian women attending the hospital.

(*Mr. Hignell.*) For some years at least he would like to see a substantial proportion of European medical officers of the better type remain in the medical services of the country. He would introduce the Indian element, as far as practicable, without any loss of efficiency.

If it was considered impracticable to hold simultaneous examinations in England and in India he would approve of the suggestion to go on recruiting a certain number of Indians by competitive examination in England and to reserve a definite percentage to be filled by a separate examination in this country which would be practically of the same standard as that held in England, although it would not be held at the same time. Such men should be sent to England for a year's practical training and should undergo a second test as in the case of the Indian Civil Service. Europeans recruited in England should devote some time to the study of the language and learn the habits and customs of the people.

(*General Giffard.*) Of the students who passed out of the Belgachia college some undertook private practice and some obtained employment in factories and industries. There was a great field for them, at present there being one medical man for 18,000 of the population. The Kavirajis also were holding their own, but the field was large enough for both. The graduates would be able to make a living and earn Rs. 300 to 400 a month, even in villages.

With reference to the remark contained in his written statement that independent medical practitioners should be given a chance in the State service, and with refer-

5. March 1919.]

DR. S. P. SARBADHIKARI.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

ence to the question that State service and the independent profession were quite different things, he explained that members of the latter were in many respects in an inferior position. They could not grant a certificate and the people came to regard them as inferior. In the case of an Indian Medical Service officer his practice depended quite as much on the position he held in Government service as on his own merits. This position was virtually denied to the class forming the independent medical profession. A private practitioner could not be recruited into the service straightaway however eminent he might be. An eminent physician in England had been selected to go as a consulting physician to Mesopotamia and granted military rank according to his position. Such a thing would be impossible in India. A person of the position of Sir Nilotan Sircar could not hope to be selected as a consulting physician to the army to advise army officers. This state of things should be remedied and suitable persons of the medical profession should be taken into State service. With regard to the question whether he would consider it preferable that Government should continue to subsidise independent colleges run by private practitioners, rather than give them appointments in

Government colleges, he stated that both systems should go on, because the number of posts at the disposal of Government to offer to these independent practitioners will necessarily be small.

In reply to a question as to whether he intended that a certain number of posts should be reserved for members of the independent medical profession to be recruited direct, or that they should be invited to work as honorary helpers, he explained that the intention was that both avenues should be open to them. Those who were high in the profession and did not care for emoluments should be taken as honorary helpers and the others should be taken as regular Government servants.

His intention was that the independent medical profession should form a recruiting ground for State service. At present when, for instance, a civil surgeon fell ill, the assistant surgeon took charge in his place, and in some cases even sub-assistant surgeons did so, but a capable independent practitioner quite fit to take over charge was never given a chance.

He desired both that Government should subsidise colleges started by independent medical practitioners and that they should also take them as professors in Government colleges.

LIEUTENANT-COLONEL SIR WALTER ECHANAN, K.C.I.E., I.M.S., Inspector-General of Prisons, Bengal.

Written statement.

Questions to witness.

Replies.

1. Defects in organisation. I know too little of the working of the Royal Army Medical Corps to answer this.

2. As far as I know, Yes.

Criticism to scheme B, which I prefer.

Scheme B, Para. 3.—More officers for civil employ. This is essential, if we are to have a war reserve.

Paragraphs 3, 4, 5, 6, 7, 8, 9.—I agree.

Paragraph 11.—The question of pensions for all officers is not raised in these papers. It is a very important matter and improved pensions are urgently necessary. As for Royal Army Medical Corps men joining Indian Medical Service under paragraph 11 any actuary could work out a fair scheme.

Paragraph 12.—Military promotion from civil.

It is generally admitted that to promote direct from civil to military is absurd, but none of the schemes recognise the fact that in most cases the civil officer is forced to accept the unasked for promotion or to go, i.e., retire on a smaller pension even before he has completed his 30 years' full pension service.

I am all in favour of asking all Indian Medical Service men when they reach 19 or 20 years' service to state definitely if they wish to remain in civil and look forward to civil administrative promotion, if so, let them remain. If, however, they wish to take their chance of military promotion they should as soon as convenient be reverted to military duty.

Paragraph 13.—The "residuary" appointments should be kept as low as possible and consist of administrative appointments (civil hospitals, prisons, and sanitary) and important teaching appointments or superintendentships of medical schools. Certain minor professorships need not be "residuary."

Paragraph 14.—I see no reason why civil employ administrative appointments should not carry definite military rank, as is done in Royal Engineers.

The Warrant of Precedence does not provide for civil medical administrative posts, and men are classed by their army rank. And unless such social precedence corresponding to present army rank is given, their position would be intolerable and absurd.

Paragraph 15.—*Seconded officers.*—Indian Medical Service men should be allowed to apply for civil employ after 2 years' service in India and should be given over to civil employ as vacancies occur, and as they can be spared, as soon as possible after 4 years' service in India have been completed. It is not possible to fix

5 years or any definite time, but as soon as after 4 years' service (i.e., after coming out to India) as is possible. It will depend on the one side on vacancies, on the other on ability to spare the officer.

I confess I cannot understand the recommendation in paragraph 15. In line 5 of that paragraph one might almost imagine "civil" for a misprint for "military," but the added personal "I" remark shows that this is not so (here two hands are evident, an original note and a marginal comment, now incorporated).

To turn a man out of civil at 20 years' because he has not a residuary civil post is absurd. Let him remain in civil and still be part of the war-reserve.

As said above personally I would insist on a man in civil employ (at 18 or 20 years' service) being asked to decide if he desired to (i) revert to military and look to military promotion, or (ii) to remain in civil and form (as long as fit) a part of the required civil war-reserve and look only for civil administrative promotion.

Paragraph 16.—I agree.

Paragraph 17.—Advisory Boards are in fact in existence, but are not so called. No one man decides these matters. The local government (if it has the choice) acts on the advice or recommendation of the medical head of the department, the Secretary and the Member of Council; finally it is decided by the Governor himself.

As for appointing combatant military officers to help a Board to decide on medical promotion, the suggestion is decidedly Gilbertian.

Frequent change from civil to military employ is simply impossible. The transfers in addition to the usual civil or military (intra-provincial) transfers would be ruinous in cost and no civil government, nor military administration would care for such frequent changes.

The Indian Medical Service men in civil employ as forming the first war-reserve must receive military training. They get it for 4 or 5 years before transfer to civil employ, and they should be given another 6 months of military duty at (soon before or soon after) their next step in promotion to major. All civil Indian Medical Service officers should again receive 6 months' training in military work at any convenient period from 18 to 22 years' service.

In both cases (i.e., military training at majority and lieutenant-colonelcy) arrangement should be made that combined leave or furlough should precede or follow the military training. This is necessary to avoid unnecessary changes and transfers. In the later course of training the deputed civil Indian Medical Service officers would probably hold command of an Indian station hospital and they should be specially trained

5 March 1919.]

Lieutenant-Colonel Sir W. BUCHANAN.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

in military administrative work. As I said above, if a man wants or hopes for military promotion, he should revert to military employ as soon after 20 years' service as is convenient, or earlier.

The frequent interchange is impracticable.

Paragraph 19.—Alteration in leave rules.

If the condemned system of "frequent interchange" was brought in it would puzzle the most accomplished actuary to work out a fair scheme of civil and military leave pay. If, as I suggest, no change would be needed, the period of training would count as civil employ.

Paragraphs 20 and 21.—I agree.

As regards the allotment of provinces the language question cannot be overlooked. A man with a knowledge of Telugu or Tamil would be most useful in Madras presidency and such a qualification for civil should not be ignored altogether, when the time for actual choice came.

Paragraph 22.—Yes, sympathetic but vague.

Paragraph 23.—This is all-important and means much to the future of all the European civil services in India. The remedy prescribed will not suit many provinces. A European Indian Medical Service officer in every district is not possible but it should be possible to have at least one European medical officer in each division, probably at the divisional headquarters and he should have a sort of "visiting charge" when required, of all European Government officials and their families in that division. Rules could be framed for his travelling allowances, fees, etc., and he should be allowed to start at once in anticipation of formal sanction to leave his district.

I have above noted points in which I differ somewhat or materially from scheme B, but it is far the most practical. Scheme A is (unconsciously) insulting and paragraph 3 at the end is based on total ignorance of the facts of life in India and is condemnatory of all European services in India.

Question 4.—Results of withdrawing Indian Medical Service officers. I prefer to answer only for jails. If the withdrawal of trained officers is for a limited period as in previous frontier, etc., wars, the damage done is slight and things soon resume their normal standard when the trained men return.

In a long war like we have just come through there has been a great strain. Speaking for Bengal I think there has been deterioration in jail management, in discipline chiefly. The old men promoted from being assistant surgeons to be civil surgeons are seldom capable of managing a jail and are in the habit of too largely leaving it to their subordinates. The result is seen in the increased number of quarrels between Indian superintendents and Indian jailers and between the superintendent and the Indian warders. I have had more such cases to settle in the four years of war than in the 12 previous years I have been in charge of the Bengal Jails Department. That things have run so well I attribute chiefly to the fact that we have (in Bengal) a lot of excellent trained and experienced jailers. In a prolonged war some deterioration is inevitable, but it will be set right as soon as trained and experienced men return. For short emergencies no appreciable harm should usually be felt.

Question 5.—I think scheme B will meet the needs of the civil administration. In the case of a war on a large scale conditions would be better in the new scheme than was the case in 1914-18 because it proposes to keep a larger war-reserve from which men would be called up gradually. The great war upset many things in Europe even more than in India.

Questions 6 and 7.—The scheme will necessarily be accompanied by the formation of a second civil war-reserve composed of medical men either European or Indian who join the reserve, and by civil assistant surgeons who also join this reserve, preferably as a condition of Government employment. Such a medical reserve must be trained in military duties, and apart from men out of India on furlough it should be present in India.

Question 8.—The civil Indian Medical Service has proved a valuable reserve for war; but must be used in a more intelligent way than has been done in

1914-1918. Indian Medical Service men in civil employ should be used in war with due regard to their special qualifications as physicians, surgeons or sanitary officers or as professional specialists; for example, civil surgeons can be used as physicians or as surgeons according to their proved fitness or as operative surgeons. Sanitary officers should be used as such in military; jail superintendents can be used as commandants of hospitals, as sanitary officers or as registrars. The main point is to recognise their special qualifications and not to treat them simply as medical officers. I have known of the case of a brilliant surgeon wasting his time and special knowledge as head of a hospital. He should have been posted as a special operative surgeon.

Question 9.—The system of recruitment and education should be that in force before the war—examination in England, competitive as before. For Indian candidates for Indian Medical Service special training in England, before the examination, in midwifery and diseases of children, etc.

Question 10.—Study leave is essential and in every way desirable. The study leave rules need but little modification. The difficulty has been the want of a sufficient leave-reserve. If the leave-reserve is increased (as can be done by allowing a greater number of men to belong to the civil department war-reserve) the question of study leave will settle itself and will enable a man to take leave *plus* study leave. Such study leave should usually be granted along with ordinary furlough. It is desirable that two periods of study leave each for six months should be given to all Indian Medical Service officers, once before 12 years' service, and once again before 24 years' service.

Question 11.—A research department is essential and inducements should be such as to keep men contented in it by incremental pay, equal to the average of men in other branches of civil or military employment.

Question 12.—I have not done any private practice for many years, but as head of the Bengal Jail Department for nearly 17 years I have visited every civil surgeon in the Presidency yearly and often discussed this matter with them. I have no doubt whatever that private practice has seriously declined and I agree with the statements made on this subject laid before the Public Services Commission. The main reasons for its decline in the mofussil are, (1) the greater facilities given by railway for visits to the big cities like Calcutta or Bombay; (2) the increase of Indian practitioners of an improved type in more towns, and (3) the marked increase of Government work thrown on civil medical officers.

Questions for service officers.

1. I was in military service for four years and since then in civil employ in Bengal.

2. I have no substantial personal cause for discontent beyond the difficulty of getting leave, the fixity of the pay and the great increase in cost of living and the present inadequacy of the pensions. Personally I have had no increase of pay since July 1902.

3. I have had no opportunity of seeing much of the Royal Army Medical Corps work in India and have no firsthand experience of friction.

4. No.

5. Limits of service.

Transfer from military to civil employ as soon as can be after four years' service in India. From civil to military, if a man dislikes civil employ he should be allowed to revert to military at any time convenient to the military authorities. At or near the period of 20 years' service a man in civil should be called upon to decide if he wished to look for either civil or military promotion. If for military promotion he should be reverted to military duty as soon as convenient to the military department; if he wishes to try for civil promotion he should remain in civil and if he does not hold one of the "residuary" appointments, he should still be liable for civil war-reserve as before.

Special questions.

1. Racial predilection is natural and undoubted; and rightly or wrongly there is also a feeling among the

5 March 1919.]

Lieutenant-Colonel Sir W. BUCHANAN.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

European servants of Government that European medical men are more reliable, more efficient, more likely to be up-to-date than Indian practitioners.

2. There have been many complaints, but the civil services know the facts and have to put up with them. In certain cases they went to the big towns or cities for the medical advice they needed, especially in midwifery case.

Efficiency of Indian medical officers of various grades.

On the whole they have improved; their education is better. This refers, I understand, to natives of India, assistant surgeons and sub-assistant surgeons.

Medical Stores Department.

I only speak of the provision of drugs and equipment for jail hospital. They come from the Medical Store Depot and for this they are amply sufficient. Annual indents are the rule, but emergent indents are not uncommon.

2. The responsibility for indenting lies (in jails) with the superintendent, who is usually also the medical officer, but all indents are examined and countersigned by the Inspector-General of Prisons, if (as usual) he is a medical officer.

3. I would gladly see increased use made by other civil departments of the Medical Store Depot, but the depot is tied up with red tape and there is often much delay, especially in emergent indents. Moreover drugs and instruments should be made and manufactured in India and large reserve stocks should be kept of all articles not liable to deterioration.

4. The present method of indenting for medical stores is wasteful. A huge tome is to be filled in in triplicate. Hundreds of drugs and instruments are printed in this list, many of which are of the nature of substitutes. The ordinary Indian medical practitioner has an innate love of new drugs and as long as the long list shows them he has only to fill in the quantity column; and consequently he asks for many drugs not necessary and not even well known. The remedy is to publish a list of drugs available, *separately*, and the name and quantity of each desired should be written down in full in the indent form. The present system leads to extravagance, and it is hardly possible for any administrative officer to properly check or control unnecessary demands.

Questions to be asked of officers regarding assistant and sub-assistant surgeons.

Question 1.—No personal knowledge.

Question 2.—No personal knowledge.

Question 3.—No personal knowledge.

4. The province could largely supply assistant surgeons provided the pay, etc., offered was liberal enough to tempt them. Their places were and could be taken by newly qualified men.

5. I think such an agreement both desirable and necessary, as a condition of employment by Government. Such liability to hold up to 15 years' service.

6. There is a demand for more medical men for the very unattractive rural areas. The towns and cities are liberally supplied with medical men of all sorts and conditions. Local authorities should employ more qualified medical men, especially of the sub-assistant class, but to get them to serve in the more rural areas a retaining fee is necessary—otherwise medical men flock to the towns.

7. The military sub-assistant surgeon. I have no personal knowledge.

8. No information.

9. No information.

10. No information.

11. No information.

12. No information.

13. The military assistant surgeon was not allowed to relieve the demand for medical men in civil employ during the war, because, in a majority of cases, he was recalled to military duty and his place taken by civil assistant surgeons.

14. The military assistant surgeon is admirably trained and adapted for such posts as superintendents in large civil hospitals, railway appointments, emigration appointments, etc.

15. The present education for military assistant surgeons is quite inadequate; it can be improved and I think further recruitment of an improved class very desirable in India.

16. Yes, but the first thing to do is to raise the standard of *preliminary* education. I understand at present he is unable to be enrolled as a medical student. He should be encouraged to take out the Intermediate Arts examination or its equivalent.

17. If so educated he could be employed as mentioned above in reply to question 14, and also in the minor civil surgeoncies.

18. No.

LIEUTENANT-COLONEL SIR WALTER BUCHANAN, called and examined.

He preferred scheme B on the whole.

He was of opinion that all Indian Medical Service officers when they reached 19 or 20 years' service should be asked to state definitely if they wished to remain in civil and look forward to civil administrative promotion, and if so, they should be allowed to remain there. If, however, they wished to take their chance of military promotion they should as soon as convenient be reverted to military duty. It was difficult to fix the exact date at which they should come to the civil side as this would depend on the number of vacancies, but they might do so after about four or five years' service.

Jail discipline had very much deteriorated during the war.

It was necessary that the central jails should be in charge of medical officers, otherwise there was bound to be friction.

He had been Inspector-General of Prisons in Bengal for 17 years, since 1902. He agreed with the recommendations of the Jail Committee of 1899 that all superintendents of central jails should be commissioned officers selected for jail service as soon as possible after they completed their military service and had acquired a good knowledge of the vernacular. He would maintain the jail cadre, but suggested that there should be a sufficient leave reserve. At present the jail department always got untrained officers to replace those who went on leave. The department had to apply to the Director General, Indian Medical Service, who supplied officers

who had no previous experience of jails. There should be a reserve of one or two trained men to provide for leave vacancies.

An officer of the jail department should have the option of reverting within two or three years of his appointment, and Government should also have the option of reverting him if they considered it necessary.

(General Hehir.) The number of "residuary" appointments should be kept as low as possible. There was bound to be dislocation in the medical services of the country in a big war like the recent war and it was not possible to avoid it. He was not in favour of increasing the number of "residuary" appointments. From the civil point of view the greater the number of such appointments the better.

The Indian Medical Service was said to have failed as regards military administration, and the army considered that their education in the military sense had been neglected. That was one of the reasons why the Director, Medical Services in India, had never been chosen from the Indian Medical Service. In order to militarize the Indian Medical Service and to remove this stigma, it might be well to consider the suggestion that Indian Medical Service officers should be taken away periodically from the civil side and given military training. Frequent changes from civil to military would, however, be undesirable. The officers should not be eternally on the move as this would make the service very unattractive. His idea was that officers

5 March 1919.]

Lieutenant-Colonel Sir W. BUCHANAN.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

should have four or five years' military training to begin with, and then five or six years later they might have another period of training which could be combined with study leave.

The services of Indian Medical Service officers who were transferred to military duty during the recent war were not utilised to the best advantage. He himself had no experience but had heard curious stories about the want of proper organization.

A large number of Indians must be expected to join the medical services. He would gladly welcome the idea of examinations being held in India as well as in England but recognised that there were great drawbacks in it. In such a case the proportion to be admitted by the two examinations would have to be fixed. He was of opinion that the larger the number of British trained officers in the service the better would it be.

With regard to Government Medical Store Depots he considered that large stocks of non-deteriorating drugs should be kept in these depots.

There were great delays in the supply of drugs by the store depots. To prevent this it would be a good thing to establish secondary depots at headquarter stations of the provinces.

At present there was a great deal of red tapism in the management of the depots which caused the delays complained of. If a business man were in charge, this sort of red tapism would not be allowed. He had not thought over the suggestion to place a business man in charge of the depot, but in case one were employed he would have to be paid highly.

(General Hendley.) With reference to the suggestion made by one of the witnesses that in future Indian Medical Service officers should start from the point where the assistant surgeons started at present, and should be in subordinate charge say of a sadar hospital, he was of opinion that if it were adopted it would not be possible to get properly qualified officers from England to come to India. If they were posted to hold charge of small civil hospitals there would not be the same strong objection, but if they had to stay there very long they would prefer to go back to military duty.

(Sir T. Nariman.) A certain number of the appointments of professors in medical colleges should be reserved for the Indian Medical Service, while a few should be open to Indians as at present.

Indian candidates for the Indian Medical Service should have special training in England in midwifery and diseases of children, etc., before taking the examination. He admitted that the teaching of midwifery, even in England, was not quite up-to-date, and there was room for improvement, but it was much superior to that obtainable in India.

(General Giffard.) He would be in favour of making it possible for a senior medical officer in civil employ

to obtain promotion and extra pension without having to revert to military duty, either by making him a consultant or by some other form of specialisation.

Bengal was well supplied in the way of roads and bridges and there were no difficulties of communication. It was possible to travel all over Bengal. There would thus be no hindrance in making the divisional headquarters centres for the distribution of medicines.

In view of the recommendations of the Public Services Commission a number of the professorial appointments should be thrown open to Indians.

Nothing less than a leave reserve of 33 per cent. would satisfy the needs of the Indian Medical Service. The present leave reserve was 20 per cent.

He did not care whether study leave should be termed "study duty" so long as it was possible for officers to get it. Before the war they could not get leave until they broke down. The grant of study leave was very desirable.

He would be sorry to see the military assistant surgeons abolished as a class, but could not see how they could remain under the new Registration Act.

He doubted very much whether the Anglo-Indian community would be able to educate their sons up to the university degree standard. Many of them got employment on railways quite early in life and with the abolition of the military assistant surgeon class Anglo-Indians, with a few exceptions, would not be attracted to the profession.

The increase of pay, the improvement on the military side, which would follow the introduction of the station hospital system, better provision for the grant of leave, the grant of study leave, and the fact that the civil side would be reserved as much as possible to the Indian Medical Service, would make the service attractive to young doctors in England. It was difficult to say whether with an increase of 33 per cent. in their pay Indian Medical Service officers would be able to save enough to take their families Home during leave. The cost of living was increasing all over the world and India was no exception.

(General Hehir.) If the competitive examination for the Indian Medical Service were held only in London he would not fix any limit to the number of Indians who might be admitted to it, but if there were a local examination in India it would be necessary to fix a proportion. It was essential to keep as much of the British element as possible.

(Mr. Hignell.) When speaking of simultaneous examinations in India, he meant local examinations. He did not think it would be possible to hold simultaneous examinations in England and India, and saw very great difficulties in doing so.

6 March 1919.]

The Hon'ble Mr. P. C. MITTER.

*(The schemes and questions referred to by witnesses are contained in Volume III.)***At Calcutta, Thursday, 6th March 1919.**

PRESENT:

THE HON'BLE SIR VERNEY LOVETT, K.C.S.I., I.C.S. (*President*).

MAJOR-GENERAL G. CREE, C.B., C.M.G., A.M.S.

MAJOR-GENERAL P. HSHIR, C.B., C.M.G., C.I.E., I.M.S.

MAJOR-GENERAL H. HENDLEY, K.H.S., I.M.S.

THE HON'BLE MAJOR-GENERAL G. G. GIFFARD, C.S.I., I.M.S.

S. R. HIGNELL, Esq., C.I.E., I.C.S.

LIEUTENANT-COLONEL A. SHAIRP, C.M.G., Indian Army.

and, as co-opted members, SIR T. NARIMAN, Kt., and LIEUTENANT-COLONEL BHOLA NATH, C.I.E., I.M.S.

MAJOR A. A. MCNEIGHT, I.M.S. (*Secretary*).

THE HON'BLE MR. P. C. MITTER, C.I.E., Calcutta.

Written statement.

As one unconnected with the medical profession I do not feel that I am competent to discuss the various points about salaries, promotion and other details, and I refrain from going into such points. I propose to speak mainly from the point of view of public interests. I am aware that there are differences amongst the several sections of the medical services and the medical profession, *e.g.*, the Royal Army Medical Corps, the Indian Medical Service, and the independent profession. I do not propose to enter into the merits of such differences. I propose to state the broad outlines of what is wanted in the public interests and I shall leave it to the Committee to decide how the wants can be met by a detailed scheme, if the Committee happen to accept my view of the matter.

The first main point we have to keep in view is that the requirements of the civil side as also of the military side must be safeguarded. As regards the military side, we must also remember that in peace times the requirements will be comparatively less, but we must always be ready for emergencies. I propose to take up the civil side first. I am of opinion that in the past the requirements of the civil population as regards training of adequate number of poor men's doctors for medical relief and the necessities of sanitation have been neglected. It has been said that for this neglect the administrative officers of the Government are responsible. I respectfully venture to differ from this view. The anxiety of high administrative officers of the Government in these directions is well-known, but it is natural that the administrators would depend upon their expert advisers for definite schemes. By way of illustration I would say that the Government of Bengal, for example, would depend upon the Surgeon-General, the Principal of the Medical College

and the Sanitary Commissioner for definite schemes relating to medical education and sanitation. As regards the officers themselves who held those important posts say for the past 10 years, they were, I believe, all very capable men but the system under which they worked was unsatisfactory. The system has been such that often they were in the beginning unfamiliar with local problems, and soon after they became to some extent familiar they were taken away from their posts. The result has been that in rural Bengal we have 1 doctor to 42,000 people in a province notoriously unhealthy. If the services be unified as primarily a military service, the interests and requirements of the civil population are bound to suffer. It is only natural that such an officer will feel that he is a military officer first and a civil officer next. The interests of research and scientific investigation also require much attention in the future. I am therefore of opinion that there should not be an unified service for both military and civil duties.

There should be two services, one for civil duties and one for military duties. The services should be recruited by open competition. In the higher branches of the civil side there must be for a long time to come a large number of European medical officers. In order to provide for military requirements in times of emergency I would arrange for the training of the civil officers as a militia. Every civil medical officer, or such number of them as may be necessary, should receive military training and should form a special reserve for military requirements. This will be a condition of his service.

My view being that there should be two services I do not accept any of the schemes A, B, C or D.

THE HON'BLE MR. P. C. MITTER, called and examined.

(*President.*) He was in favour of having two services, one for civil duties and one for military duties. The service should be recruited by open competition partly in India but mainly in England. He would make it compulsory for those recruited in India to take a further course of training in England.

Western methods of medicine were making progress to a fairly large extent in rural Bengal. At the present time there were 3,000 registered medical men in Bengal. The bulk of them practise in municipal areas. Many who are trained in the medical colleges find employment in rural areas.

There were fair prospects in districts for young men who obtained their degrees in medical colleges

in Calcutta. His idea for the future of the medical profession in Bengal was that there should be more poor men's doctors, men who would be content to charge small fees. He would expect these men to make a living in rural areas where they would earn Rs. 75 or Rs. 100 a month. At the present moment there were only one thousand men of this type. Eight to ten thousand more were required. The more men there were of this type in rural areas the better were the chances of medical graduates in big towns. He thought that the doctors turned out by the Campbell Medical School were good enough for rural populations.

A scheme for providing medical relief in rural areas had been taken up by co-operative societies specially

6 March 1919.]

The Hon'ble Mr. P. C. MITTER.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

organised for that purpose. The Registrar of the Co-operative Societies and the Sanitary Commissioner had approved of the scheme in its outline. The idea was to start co-operative societies with memberships. A first class member would pay about Re. 1 a month and would have the services of the medical officer free and medicine at cost price. The medical officer would have the liberty of private practice among non-members. A second class member would pay six or eight annas and he would have to go to the doctor's residence or dispensary for treatment; medicine would be supplied at cost price to second class members also. A portion of the income would be spent on sanitary organization. At present work had been started only in four villages. There were altogether in Bengal about 1,758 villages and the population of each village was from 2,000 to 5,000. There were about 200 towns, some with municipalities and some without. The total population of these villages and towns would be about 8 millions. The scheme at present was in its infancy but the prospects of its success were good. He did not think the scheme would require large funds. For this class of work he would employ men who had been trained in one of the government medical schools. If private practitioners were employed they would naturally ask for a higher remuneration. Graduates would demand Rs. 200 a month. Last year the society spent about twenty or thirty thousand rupees. In case of sickness both European and Indian doctors have been called in. Preference has not been shown for any particular kind of doctor.

The prospects of a medical career for young men had been looked upon with a certain amount of favour by parents, though, as a matter of fact, more money could be made in the legal and industrial line than as a doctor. Still, a doctor's position was always assured and he would never starve. The medical profession was increasing in popularity. The number of applicants wishing to enter the service was very large.

(General Hendley.) His scheme really aimed at getting a medical officer who would accept a low rate of salary. He did not think that his scheme would break down even if sub-assistant surgeons were given a five years' course, as a great deal would depend on what remuneration was given. In villages with a population of only 2,000 it might not be attractive but in villages of more than that it would be attractive. If a start was made with men who had undergone the four years' course the conditions of the people would

improve. Other co-operative societies had been established but they were not doing very much.

(Sir T. Nariman.) He was not trying to provide for the school trained doctor to the prejudice of the college trained doctor. He thought that the school trained doctor was necessary for the poor section of the community who could not afford to pay for the college trained doctor. The requirements of society were such that there was scope both for the school and college trained doctor. He considered that the school man will pioneer the work and will send cases which are beyond his powers to the college man who will be found in the nearest town.

In the Bengal Council three resolutions were introduced, the charge being that the public in Bengal did not favour western medicine. One resolution aimed at providing a certain sum of money for the establishment of an Ayurvedic institution in Calcutta. This resolution was opposed by non-official members. There were two other resolutions relating to permission being given to students of medical schools to appear in examinations contrary to the provisions of the Medical Act of 1914. One at any rate of these resolutions was passed, and the resolution that was passed was supported by the non-official European members, representatives of Chambers of Commerce, and men like Sir A. Birkmyre, and the reason why this resolution was accepted was that the Medical Act wanted to give retrospective effect to its position and in that respect the Medical Act here differed from the English Medical Act.

(Mr. Hignell.) As regards his experience of Bengal, he had had a lot to do with rural areas in his younger days. He knew Nadia, 24-Parganas, Faridpur, Khulna and a portion of Midnapore. His scheme was a pioneer scheme meant for the alleviation of sickness amongst the poorer classes.

(General Giffard.) He thought that a sub-assistant surgeon, even if he was a servant of the Co-operative Society, would make private practice, and the society had arranged that as the receipts of the society grew the pay of the medical man would rise. He intended to safeguard the medical officer from exploitation by a rich society and from sweating by rich men joining the society.

He advocated the creation of a permanent civil medical service. The permanent officers of such a service would be better able to look after the interests of the civil population by studying local problems and specialising in them.

SIR KAILAS CHANDRA BOSE, KT., C.I.E., O.B.E., I.M.S., Calcutta.

Written statement.

The scheme for a unified military medical service for India with a civil medical service as a reserve is an important subject and as such it requires our most careful consideration. I do not foresee the good that underlies it, nor do I find the necessity of disturbing the arrangement under which men for the Royal Army Medical Corps and Indian Medical Service are at present recruited. I fully appreciate the project that contemplates provision for future military emergencies, but at the same time I cannot ignore the very reasonable demands of the civil population for medical relief. The idea of unifying the two separate services is, I fear, a mistake and will complicate matters. True it is that Royal Army Medical Corps men have hitherto done splendid work both in the field and barracks, but how far they will prove a success in dealing with questions relating to health and diseases of the civil population is a problem which requires solution. Indian Medical Service men who have spent years to learn the various phases of diseases which often affect civil life such as plague, Kala azar, hook-worm—diseases which are almost foreign to the military men, some of whom may have made special study of gynaecology, ophthalmology, etc.—will it is feared be

not very useful in field work. It is now suggested that the two services be united as one and the officers will at the discretion of the authorities have to act for some time in one and some time in another line so that they shall be eligible for both kind of services. The result will be that both the services will suffer and it would be no good to the State nor to the people.

If in the wisdom of the Committee it appears sound and expedient to give the benefit of the unified medical service for India to the Indian, and Anglo-Indian, nothing could serve the purpose better than by holding a competitive examination of students passed out of various medical colleges or by establishing a separate college out of various medical colleges or by establishing a separate college for the recruitment of a body of well-trained Indian or Anglo-Indian medical men capable of being enlisted in the army after fulfilling the requisites needed for military service. The idea of replacing the Indian Medical Service by these men is not sound in principle; on the contrary the Indian Medical Service should be strengthened and the existing privilege of admitting Indians into it should also be retained; this will I doubt not satisfy the growing aspiration of Indian medical men.

6 March 1919.]

Sir KAILAS CHANDRA BOSE.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

To satisfy the demands of really good men whose means do not allow them to go to England and compete for the vacancies that annually occur in the Indian Medical Service, 5 or 6 scholarships should be created and a separate competitive examination be held to enable the successful candidates to go up for the service examination. The fund may be met from the Government treasury or from the University. The Indians are proverbially loyal and most willing to serve their Sovereign. They have given ample evidence of this special attribute during the recent war. The Services Committee have chalked out a scheme for an auxiliary corps in India, but they have not dealt with the question of maintaining it. People who form the Corps must necessarily require allowance for their own maintenance as well as for those who depend upon them. An anomaly which exists in the service of sub-assistant surgeons and the military subordinate assistants should if possible be removed early. Although the education of the civil sub-assistant surgeons is superior to the medical education of the military subordinates, still in service the civil is placed under the military subordinate assistants. This creates heart-burning and dissatisfaction amongst the civil sub-assistant surgeons.

If it is finally decided to give effect to the scheme of a unified medical service for India as at present chalked out, the medical tuition of the country will suffer materially and the project will ultimately prove a retrograde step. At present the professorial chairs of medical colleges are occupied by men who have made special study of the subjects they profess but under the unified medical service system experience and age will not be taken into consideration in filling up the

chairs. The military institutions will prosper at the expense of the health and well-being of the civil population.

I need not in this place discuss the question of pay of officers, assistant surgeons and sub-assistant surgeons for it is I believe well-known to the authorities. The assistant and sub-assistant surgeons hold responsible offices but they belong to a class of half starved loyal servants of Government whose duties do not divide Sunday from the week and who are altogether deprived of the privilege of public holidays. Their services are often placed under deputy magistrates who are not half so learned as they are. It would I fear be very difficult to get men for research work only; hitherto it has been done by Indian Medical Service men who again induced their assistants to co-operate with them. With the exception of the laboratory men the number of such workers is very limited and special arrangements should be made to increase it.

The post for sanitary commissioners should be at present restricted to Indian Medical Service men with special qualification; the deputy sanitary commissioners should be selected from the Indians who hold the degree of D. P. H. of the Calcutta University. For the efficiency and better government of the medical service it would be necessary to retain the services of the inspectors-general for they are the men who by their experience and age have acquired sufficient knowledge of the real wants of the people of the country and how best to supply them. In appointing men for schools and colleges they are the best persons to sit in judgment over the respective claims of candidates.

SIR KAILAS CHANDRA BOSE, called and examined.

(President.) He was an independent medical practitioner. He had been practising in Calcutta for the last 43 years.

He did not believe in a unified military medical service for India with the civil medical service as a war reserve. He would advocate the continuance of the present system with reference to both Royal Army Medical Corps and Indian Medical Service, for reasons given in his written statement. There would not be any paucity of English candidates for more than two years. Now-a-days Indian students were going to England in greater numbers to compete for these coveted appointments and they might come out successful in any competitive examination that might be held.

The prospects of assistant and sub-assistant surgeons should be considerably improved. At present they were very inadequately paid, too hard-worked and allowed no holidays.

He would restrict the posts of sanitary commissioners to Indian Medical Service men with special qualifications and would select deputy sanitary commissioners from Indians who held the D. P. H. of the Calcutta University.

The Kavirajas of Calcutta were getting more practice by surreptitiously using western drugs; and they had prospered at the expense of legitimately qualified doctors. In a way, he said, these Kavirajas were maintaining the position which they had thus fraudulently obtained.

(General Cree.) There was a desire generally among Indian medical graduates to join the army. In fact two of his nephews, of whom one was now a captain, took a fancy to field service, and he had sent them. He would not say that it was merely a passing desire. He had not studied the subject; but from the attitude which the young men had taken, he was convinced that at least some, though not all, would stick to the army. There were also, perhaps, some who might have joined the army with the sole object of getting some lucrative appointments later. If Indians were asked to serve abroad for 20 or 25 years, they might demur, but that was quite natural.

(General Hehir.) In his view, the system of unified military medical service would interfere with the medical requirements of the civil population. If it was decided to give effect to this system, he would urge, as an alternative, to allow Indians to appear at a competitive examination to be held in India and to send the successful candidates to England at Government expense to complete their medical education. The Principals of the various colleges could be requested to nominate a certain number of candidates for the examination.

He was in favour of instituting a system of scholarships for enabling Indian students to go to England to compete for the service examinations.

The educational work of the Medical College in Calcutta was being carried out satisfactorily by the members of the Indian Medical Service; he did not think that the independent professional men could do so well.

(General Hendley.) Sub-assistant surgeons on the military side should receive higher education, if they were competent to receive it. The grant to sub-assistant surgeons of registrable qualifications might result in their becoming dissatisfied and leaving military service, in which case it would be difficult to replace them.

The position of civil assistant and sub-assistant surgeons was very unsatisfactory. Though these men possessed the same qualifications as military subordinates, the latter were very often given the preference over the civil men. Another grievance was that these civil assistant and sub-assistant surgeons were sometimes placed under junior officers of the provincial executive service.

(Sir T. Nariman.) The scholarships which he advocated in this written statement were intended more as a sort of inducement for medical graduates, as the Gilchrist scholarships awarded by the University are to its graduates and undergraduates, to go to England to compete for the service examinations, as simultaneous examinations could not be held in India with satisfaction. There would be no difficulty as regards theoretical examinations, as question papers could be

6 March 1919.]

Sir KAILAS CHANDRA BOSE.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

sent for from Home but the practical examinations would not be quite the same.

(Lieutenant-Colonel Bhola Nauth.) He doubted whether Government would take the risk of spending money on those who might or might not pass the examination. So he expressed the pious hope that some generous donor might come forward with the intention of starting a fund for that purpose. His proposal was meant only as a suggestion.

(Sir T. Nariman.) The professorial chairs in the colleges ought to be held only by Indian Medical Service officers, as they alone had the requisite experience and knowledge. He did not mean, however, that if Indians were appointed as professors, they would be a failure. In his opinion there were only very few Indians who could fill these posts and keep up their traditions.

The pay of the assistant and sub-assistant surgeons was very low; and they had to work very hard. He did not want to institute any comparison between one service and another. In the Indian Medical Service there might be men who would work on Sundays; but he knew of many who did not work on Sundays. He admitted that professional men had to work without any holidays for months; but their case was not on all-

fours with that of the subordinates of the medical department.

(Mr. Hignell.) He did not understand the schemes sent to him by the Committee. He was not in favour of any scheme which contemplated the unification of the medical services, if it was intended that military medical officers after five years should at any time be transferred to civil, and officers in civil similarly transferred to military. Medical science was advancing day by day and any one who desired to keep abreast of the times must work hard and be in touch with the subject he chose to practise in. A civil surgeon must be in touch with diseases and the bacteriological and other causative factors of such diseases, whereas a military surgeon should also be conversant with the most up-to-date methods of surgery, extraction of bones, etc. If a brilliant military surgeon were transferred to civil employ for some years, his brilliant parts would get rusty and he would have to start afresh if he were again reverted to military. The same would be the case with a civil surgeon. But there would not be any very great objection to both the civil and military officers knowing something of each other's work.

DR. M. N. BANERJI, B.A., M.R.C.S., Calcutta.

Written statement.

Of the schemes suggested with a view to remedying existing defects in the present organization of the medical services I prefer scheme D and accept it so far as the military needs are concerned provided that the following modifications are made:—

- (a) That the certain number of Royal Army Medical Corps officers seconded for duty in India with the Indian Army Medical Corps be gradually eliminated and ultimately the Indian Army Medical Corps be officered by its own men only.
- (b) That more facilities be given to Indians to enter this service by holding simultaneous open competitive examinations in England and in India to which medical graduates of Indian Universities possessing qualifications registrable in Great Britain may be admitted, the successful candidates in India being required to undergo a course of military medical training in England for one year.

Civil medical service.

This portion of the scheme D will have to be considerably modified or re-drafted if the suggestions stated below are accepted by the Committee.

(a) I am of opinion that the time has come when the civil medical service should be entirely independent of the military. With the introduction of a League of Nations the contingency of a war on a large scale is so remote and distant that it will not be fair to saddle the civil with a military war reserve for all times for that purpose. Besides, the experience of the war has proved that the ordinary war reserve of the military medical seconded with the civil is quite inadequate and the number of officers available from this source is negligible compared to the number of those recruited from other sources. The fact that we have now more than 800 temporary commissioned officers in the Indian Medical Service recruited mostly from the independent medical profession is a proof that there are other ways of meeting the demands of war. The scheme, suggested in scheme B, to form something of the nature of a militia or of a special reserve from the private practitioners and assistant-surgeons, holding qualifications registrable in the United Kingdom, giving a retaining fee or bonus and requiring them to undergo periodic military training

is well worth considering and will be a better and more efficient solution of the problem than the present war reserve. From the civil point of view also the necessity for dissociation of the military and the civil medical services is still more urgent in the interests of the medical profession and for the needs of the people at large. The constant changes from the military to the civil or from the civil to the military duties are not conducive to the full development of the special qualities and aptitudes of the medical officers, depriving the people thereby of the advantages that might be derived from their full development. It cannot be said that medical education is making a satisfactory progress under the present system when the teaching medical institutions are so few in this country nor that the supply of medical relief is all that could be desired when it is considered that there are only about 3,000 registered medical men in Bengal for a population of 45 millions. Under the circumstances I think in the interests of the service, in the interests of the profession and in the interests of the people it is advisable to separate the civil completely from the military medical.

(b) The special scientific and educational appointments should be a distinct branch of the civil medical service. Under the present system a professor when first appointed is no better than a senior student and by the time with industry and applications, he becomes half a professor he is transferred to some administrative post or possibly to a professorship in some other subject and a new man comes and goes through the same stages. In special subjects such as chemistry, physiology and bacteriology the new man is even in a worse position and it can be well imagined how he adapts himself to his new duties.

In the medical profession also if, under the exigencies of the service, a surgeon has to do the work of an obstetric physician or an ophthalmic surgeon, that of a physician we cannot expect to have specialists worth the name. It is therefore desirable that all appointments connected with the special sciences, medical education and research should be made by an Advisory Board aided by expert advice if necessary. Applications for these appointments should be invited from all countries and efforts should be made to get the best man available in each subject from whatever source he may be obtained. The appointments should also have such salaries and prospects attached to them as would attract the best men and enable them, when

6 March 1919.]

Dr. M. N. BANERJEE.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

appointed, to devote their whole time to their special duties.

(c) The system of recruitment for the higher grade (what is now held by the Indian Medical Service officers) shall be what I have suggested for the higher grade in the military medical service. With the standard kept at its high level and with the pay enhanced as it is, there should be no difficulty in the recruitment.

Study leave.

Special leave for study and periodic military training is absolutely necessary. Not less than six months every five years should be allowed for this purpose. A college in India similar to the Royal Army Medical Corps College at Millbank is, I agree, essential for the efficiency of the Indian Army Medical Corps.

Dr. M. N. BANERJEE, called and examined.

The witness was an independent medical practitioner and had been practising in Calcutta for about 30 years. His regular practice was confined to Calcutta though he went out to the mofussil occasionally. He had received his medical education in Calcutta for two years and at King's College Hospital, London, for three years. After qualifying at King's College he was resident medical officer of the Royal Free Hospital for Women. He had never been in Government service. He had been connected with the Belgachia College for the last 25 years, and had been teacher of medicine there, and is now the Principal of the College. He had a fairly large practice which had been stationary for the last ten years. It was not confined to men of his own class but extended to all classes of persons, Europeans as well as Indians.

The people of Calcutta were consulting more and more doctors trained in the western system of medicine.

He was in favour of an Indian Army Medical Corps officered by its own men.

The civil medical services should be entirely independent of the military. This was fully explained in paragraph (a), under "Civil medical services," in his written statement.

Medical education could not be said to be making satisfactory progress when the teaching medical institutions were so few, and there were only about 3,000 registered medical practitioners in Bengal for a population of 45 millions. People outside Calcutta did not mind whether a man was a registered practitioner. In the interior there was no medical help of any kind except the indigenous hakims. In cases of cholera, dysentery, etc., they would prefer to have a doctor but could not get one. No doubt there was a civil surgeon in charge of every district, but in the case of epidemics he had not sufficient men at his disposal to afford relief to the people. For this purpose he would like a considerable development in the subordinate provincial medical service to be placed under the local government. In the case of certain special departments, service should be under the Government of India.

For the reasons explained in his statement, special scientific and educational appointments should form a distinct branch of the civil medical service. All appointments connected with the special sciences, medical education, and research should be made by an Advisory Board aided by expert advice if necessary.

(General Hehir.) In the event of scheme D being adopted simultaneous competitive examinations should be held in England and India. Before appearing in the examination Indian students should be medically examined as to their physical fitness. The successful candidates should be sent to England for one year both for military and professional training. One year's training should be sufficient, but it might be extended to 18 months if necessary.

No doubt the present war reserve had not broken down in any of the campaigns previous to the late war, the magnitude of which was such that any organisation would have broken down; still it was necessary that the civil medical department should be separate from the military.

He upheld the opinion expressed in his written statement that, under the present arrangement, a professor when first appointed was no better than a senior student, and by the time he became half a professor he was transferred to some administrative post, or to a

professorship in some other subject, and the new man replacing him went through the same stages, though it was pointed out to him that most of the professors of the Calcutta Medical College were experts in their own line and the Calcutta University had reason to be proud of them, and that therefore the above remarks could not apply to them. He had nothing to complain about the present incumbents. It had, however, happened about ten years ago that the Principal of the Medical College came here as professor of medicine, while he had been professor of surgery in the college from which he came. It was also the practice in Calcutta that the professor of materia medica was promoted to be professor of medicine. Although this had been the practice in London also, it had been held by Sir Charles Ball and another eminent authority that it should not be so. The professor of medicine should start early in life as such, and should not be promoted to that post late in life as at present. He should start as an assistant professor of medicine.

(General Hendley.) Not only experience, but devotion also to one subject, would make a professor better fitted for his work.

Private practitioners should be so trained that in time of need Government may be able to call on them as a war reserve. Experienced assistant surgeons had not been asked to form a war reserve but many of them volunteered for service though he could not say off-hand how many. No doubt many who volunteered were fresh from college but still there were several experienced persons also who did so. Some of the teachers of the Belgachia College had volunteered and their services had been utilised. It was important that most of the persons joining the war reserve should be men of experience.

(Sir T. Nariman.) Private practitioners should be given a bonus or retaining fee to join the war reserve. Many experienced practitioners would be prepared to join it and would be willing to give up their practice for a short time to undergo military training. They would not expect to get the same remuneration as they earned themselves by practice.

(General Hehir.) He had several times left the station and asked another practitioner to act as his *locum tenens*. This was, however, not the general practice, but persons proceeding to undergo military training would be able to get *locum tenens* to take up their cases.

There were only 3,000 registered medical practitioners for a population of 45 millions in Bengal. There was a great demand for men of the type turned out from the medical schools and an increase in the number of schools was called for. The demand was not so great for assistant surgeons.

If the civil medical service was separate from the military and the needs of the civil service were not to be regulated by the needs of the military, and the head of the civil department was more free to deal with his department, he would be better able to arrange to provide for the needs of the population and for medical education. The head of the department would be of the same status as at present, but he would be able to devote his whole attention to the civil department.

(Colonel Bhola Nauth.) The statement that Indian practitioners began to suffer from diabetes after a few years and were thus unfit to form a war reserve was without foundation. He had not seen any medical practitioners being disabled in this way.

6 March 1919.]

Dr. M. N. BANERJEE.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

A sufficient number of private practitioners would be forthcoming to form the war reserve.

Educational appointments should be thrown open to all, and the best men should be recruited. It was not the intention that all teachers should be recruited in India, but there were persons in India who could hold such posts. In many subjects professors could be recruited from the Indian Medical Service or brought from England.

He could say from personal experience, both in England and in India, that the statement that European ladies objected to being treated by Indian medical men was an exaggeration. During the time he was employed at the Royal Free Women's Hospital he was in charge of the gynaecological department. No member of the governing body or any patient raised any objection to this. In India he had been practising for a long time among Europeans and had treated European ladies of great position, and had never noticed any prejudice of that kind. There may be some objection in the mufassil stations but the reason for that should be sought in other directions. It was probably due to the fact that Indian medical men there were mostly of the subordinate class, and the European medical officers were of the superior status, and generally ladies preferred a medical man of the higher standard professionally, though they did not attach much importance to social position. The question was not whether one was an Indian, but in case the two were of the same standard professionally European ladies would not object to being treated by any of them.

(General Giffard.) More facilities should be given to Indians to enter the military medical service.

The advantage from a separate civil medical service would be that the department will be headed by an officer who will be able to look after the civil needs exclusively. For the purpose of the army some arrangement might be made by which, instead of the posts being mixed up, the military could borrow from the civil or the independent profession in case of necessity. At present 3rd of the Indian Medical Service formed the military reserve and were employed in civil. In spite of this the reserve had not been sufficient during the late war. That was why he had suggested that some other arrangement should be made, and the independent profession should be trained so that they may be of service in time of war. The civil medical service should not be subordinate to the military.

The Indian medical profession had shown a desire to help in this war, and several practitioners of more than five years' standing had come forward. He was

not prepared to state their number, but at least two dozen who were personally known to him had so volunteered.

In view of the explanation given as to the number of persons supplied by the war reserve he withdrew the remark made in his written statement that the number available from this source was negligible compared to the number recruited from other sources.

With reference to the suggestion in his written statement that appointments connected with special science, medical education and research should be thrown open to all, he explained that his intention was that the best men should be selected preferably from England and India. He would prefer to exclude foreign countries, but in case for some special reasons it was found necessary to recruit a professor from there he should be obtained. He admitted that specialists of the highest reputation would have to be paid very high salaries, but others might come on Rs. 1,000 as they went to Australia and Canada on this salary. The salary might be increased if necessary.

A larger number of medical practitioners, say three times the present number, could be absorbed in the country, if turned from the colleges. They would go to villages and the sub-divisions and some would be absorbed in special departments such as the sanitary department.

These persons disliked to go to sanitation as they were not trained for it, and did not accept appointment as health officers on Rs. 140—200 as the salary was inadequate. They should be paid more than the ordinary practitioners as by employment in the sanitary department they would be losing chances of private practice.

With regard to the question whether it would be better for Government to subsidize the private colleges started by private practitioners or that they should offer some of the appointments in the Government colleges to private practitioners, he replied that there should be no distinction in filling these appointments between Englishmen and Indians, and that they should be filled according to merit from both classes. Government officers should not, however, be appointed to the Belgachia College as the underlying idea in having an independent college was that it would be more economical than the Government college. The Government college was two or three times more expensive than the Belgachia College as the professors in the latter worked on much less pay in a voluntary spirit, very much as in London, than they would in the former.

7 March 1919.]

Colonel P. C. H. STRICKLAND.

*(The schemes and questions referred to by witnesses are contained in Volume III.)***At Calcutta, Friday, 7th March 1919.****PRESENT:**THE HON'BLE SIR VERNEY LOVETT, K.C.S.I., I.C.S. (*President*).

MAJOR-GENERAL G. CREE, C.B., C.M.G., A.M.S.

MAJOR-GENERAL P. HEHIR, C.B., C.M.G., C.I.E., I.M.S.

MAJOR-GENERAL H. HENDLEY, K.H.S., I.M.S.

THE HON'BLE MAJOR-GENERAL G. G. GIFFARD, C.S.I., I.M.S.

and, as co-opted members, SIR T. NARIMAN, KT., and LIEUTENANT-COLONEL BHOLA NAUTH, C.I.E., I.M.S.

S. R. HIGNELL, Esq., C.I.E., I.C.S.

LIEUTENANT-COLONEL A. SHAIRP, C.M.G., Indian Army.

MAJOR M. T. CRAMER-ROBERTS, D.S.O., Indian Army.

MAJOR A. A. McNEIGHT, I.M.S. (*Secretary*).

COLONEL P. C. H. STRICKLAND, I.M.S., Inspector-General of Civil Hospitals, Burma.

Written statement.

The following criticisms of the various schemes are offered:—

Criticism of scheme A.

This is said to be a scheme for the formation of an unified military service. It is not easy to see where unification comes in: the Indian Medical Service is abolished, but a new service is created to take its place (the auxiliary corps). Moreover, a second new service, the civil medical service, is suggested to replace the Indian Medical Service in civil employment. As regards the military services, there still remain two distinct services, one for British and the other for Indian Troops; therefore, any objection that there may be to the present dual services will apply with equal force to the proposed arrangement.

The auxiliary corps.

The civil medical service with its superior opportunities for professional work and with its prospects of private practice must present a great attraction to both Anglo-Indian and Indian medical men, and it will be difficult to obtain recruits of a desirable stamp for this corps unless the pay and prospects offered are considerably more attractive than those of the proposed civil medical service. The medical service of the Indian Army would therefore be officered by men of inferior capacity.

This being so, it will follow that the more responsible military medical appointments, both administrative and executive, will have to be entrusted to officers of the European service; the result will be discontent which will react on the recruiting, making an already unsatisfactory state of affairs still worse. In short, the scheme aims at substituting for a service which in the past has been efficient, and could be made so again, a new service, which from its birth will be unpopular and more or less inefficient.

The civil medical service and its recruitment.

It introduces a new and untried principle in seconding in civil employ, for short periods, European medical officers who in very many cases will have little or no knowledge of Indian conditions. This will probably meet with opposition from local governments, and is practically certain to result in friction inside the service itself. The whole scheme is ill-digested, unworkable and unfair to the majority of the Indian Medical Service.

As regards the disposal of present Indian Medical Service officers in military employ, they are offered the choice if, of less than 15 years' service, of elect-

ing to be absorbed into the Royal Army Medical Corps or of standing out with officers of over 15 years' service and being seconded with the Royal Army Medical Corps. They entered the service under certain definite promises from the Government and to reduce those who do not elect or cannot join the Royal Army Medical Corps, to remnants of an abolished service would constitute a breach of faith on the part of the Government.

As regards what are called "The Points of the Scheme."

(1) The scheme is not a unification, in that instead of unifying the service, it merely abolished one to replace it by another which must be inferior in practice.

(2) This adequate reserve can be much better provided for by a reorganized Indian Medical Service than by any proposal embodied in scheme A.

(3) This alleged disadvantage applies to all services under the Government of India. In the past, one of the chief grievances of the Indian Medical Service has been the difficulty of obtaining leave. With improved organization, officers may be depended on to take all the leave necessary to keep them efficient.

While the Indian Medical Service is undoubtedly in need of reorganization, the abolition of the service and the substitution for it of two services, one of which will be inferior and both discontented, does not appear to be a remedy.

Scheme B.

Scheme B is hardly a scheme in itself but comprises a series of somewhat disjointed suggestions regarding the lines on which any reorganization of the medical service should take place.

It may be again emphasised that no possible advantage can be gained by introducing officers of a different corps for short periods into the Indian Medical Service. On the other hand, the disadvantages of such an arrangement are obvious. These officers being attached to the Indian Medical Service for very limited periods would have no inducement to identify themselves with the permanent service and by not casting their lot with this service, they would fail to amalgamate with, and would form an alien element in it.

The objections to the suggestions in paragraph 24, page 6 for the elimination of the Royal Army Medical Corps from the medical service in India are:—

- (i) The scheme would not be accepted by the War Office;
- (ii) If it were adopted, it would seriously hinder recruitment for the Indian Medical Service, because it would so increase the preponderance of the military side of the Indian

7 March 1919.]

Colonel P. C. H. STRICKLAND.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

Medical Service that no man on entry could look forward with any certainty to obtaining civil employment; and this is the main inducement which brings men into the Indian Medical Service.

- (iii) The Government of India would be called upon to provide a European medical reserve for the British army in India which reserve is under the present system provided for by the United Kingdom.

Scheme C.

Scheme C is the one that commends itself most to the Indian Medical Service officers who have been consulted and failing other methods of recruiting the service, it might perhaps be adopted.

Scheme D.

Scheme D apparently is a modification of scheme A and we do not consider that it is any more suitable than that scheme and the criticisms already expressed on scheme A apply in general to this scheme also.

I attach the outlines of a suggested scheme put forward by us and to say that this scheme was drawn up before schemes C and D had been received; it will be noted that this suggested scheme approximates closely to scheme C except in as far that scheme C allows of officers of outside corps temporarily joining the new Indian Corps. This I believe to be a point on which it is not necessary to attach too great an importance.

Suggested scheme.

Retention of the present dual medical services in India with the necessary reorganization of the Indian Medical Service.

The reorganization which is essential may be outlined as follows:—

In the Indian Medical Service, the Government has at hand a service which has done sterling work in the past and for the matter of that, is doing so now; but the service is no longer popular and recruiting has fallen off.

The difficulties which the war has brought into prominence were perfectly well-known and recognized before the war, but any attempt to alter them has always been met by "non-possumus," on account of the expenditure involved. These difficulties can be easily remedied and to do so would be easier, simpler and probably less expensive than to carry out either of the schemes presented for consideration. The present Indian Medical Service could easily be made second to none in the world as a military medical service with a war reserve of officers superior to that of any other army or country, because this reserve has in its ordinary duties administrative and professional experience such as the ordinary medical practitioners who in all countries form the bulk of the medical reserve cannot and do not have. Such a service can be at once constituted by carrying out the following reforms:—

- (i) The formation of the Indian Medical Corps offered by the Indian Medical Service, and complete in every respect, with a proportion of European Sisters.

The sub-assistant surgeons should be given the rank, status and title of Indian officers.

The enlisted men should provide for all hospital duties: clerks, compounders, cooks, bhisties, stretcher-bearers, sweepers, ward attendants trained in nursing, men employed for transport duties, etc.

The terms of service should be such as to produce a large and efficient reserve of all classes which should be called up periodically for training. Everything possible should be done to foster *esprit de corps*.

Non-commissioned officers should be recruited from the enlisted men and should be eligible for clerkships, compounderships, etc., if they attain the necessary standard of education and knowledge.

This Corps should be mobilized regularly and instructed in its duties in the field and should ordinarily have enough transport to provide instruction for its establishment.

This Corps should be quite distinct and separate from the Royal Army Medical Hospital Corps.

It is presumed that the station hospital system will be universally adopted. This obviates the undesirable amalgamation of British and Indian hospitals under one command. In this connection, it appears desirable that the senior medical officer of a station should be done away with: this office with its ill-defined duties and responsibilities is the cause of most of the friction between the British and Indian services.

To carry out this scheme practically, the whole of the Indian hospitals in India will have to be rebuilt. The present hospital buildings are, as a rule, fit only to be burnt.

- (ii) The present water-tight compartments into which the civil and military branches of the Indian Medical Service are divided should be done away with, and men freely transferred from one service to the other. No man ought to be allowed to spend all his time in military duty or in civil duty.

All officers of the Indian Medical Service in civil employ should be recalled to military duty periodically for such training as is considered necessary and compelled to pass all examinations prescribed by the Army authorities. Failure to pass would involve retention in military duty until the examination was passed.

Officers who elect for military employment should spend at least one-quarter of their service up to 20 years in civil employment. This period should not be taken continuously, but in instalments of not more than two years at a time. After 20 years, they would remain permanently in military duty. Only these latter officers should be eligible for military administrative appointments. Civil administrative appointments should be similarly reserved for men who elect to remain in the civil, but up to 20 years, the two branches should be freely interchangeable on something like the above lines. In the case of some of the highly specialised branches of the civil departments, it would probably be advisable to do away with the liability to military service at an earlier date than 20 years.

These changes would give a thoroughly efficient military medical service, with a trained reserve behind it for war.

- (iii) No reorganization will be of much use, unless the units comprising this service be individually efficient. To obtain this efficiency the condition in the Indian Medical Service must be made much more attractive than they have been of late years. The strength of the service requires to be largely increased, not only to provide a large war reserve, but to enable men to get a reasonable amount of leave. Present leave rules look liberal enough on paper; but unfortunately they remain on paper. Leave is earned over and over again before it can be taken. Study leave should be compulsory to the extent of one year in twenty, and should count as duty for pay and pension. If and when the Medical Staff College proposed in paragraph 20 of scheme B materializes, this year of study should be spent at it.

The pay requires to be largely increased, and it appears desirable that as a rule it should be a consolidated pay. Pensions might, with advantage, be slightly altered. At present, the pension increases by 20 pounds yearly between 20 and 25 years' service, and is raised by 40 pounds yearly between 25 and 30 years' service. This arrangement should be reversed and the increase of pension of 40 pounds annually should occur between 20 and 25 years' service, so that an officer could retire on 600 pounds after 25 years, and 700 pounds after 30 years, as at present. This would be a considerable inducement for many men to go at 25 years, and would keep the service younger. A man is probably a good deal less efficient between 25 and 30 years' service than between 20 and 25, and if

7 March 1919.]

Colonel P. C. H. STRICKLAND.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

he stays on to reach administrative rank, would reach it at a younger age than at present.

(iv) Concerning recruitment, normally, this should be by competitive examination; but it is considered that the subjects of the examinations should be carefully considered with a view to the elimination of unnecessary subjects. But it is recognized that the immediate needs of the service in respect of recruitment will have to be met by the nomination of officers who served in some medical service during the war.

An additional war reserve should be provided from private practitioners, European and Asiatic, who, in return for appointments on a hospital staff, would undertake military training, and be liable for military service with the Indian Army.

Transfers from military to civil employ should be simplified and some of the present anomalies abolished.

It is also considered essential that the head of the Indian Medical Service should have direct access to the Government of India, and that similarly the provincial heads should have direct access to their respective local governments.

I desire to draw your attention to the fact that the schemes and questions sent by the Committee now sitting have been thrown upon us at very short notice and the various schemes and questions have come up in dribbles, and it is impossible in the short time allowed to make a full study of the question. A matter of such vital importance which will affect the conditions not only of the Indian Medical Service but of every service in India, is not one that can be rushed through in a week or a fortnight and I think that the schemes and questions should have been submitted to us at least three months before evidence was to be taken by the Committee in order that due consideration could be paid to the whole question.

ANSWERS TO QUESTIONS.

Questions for witnesses.

Q. 1.—Director of Medical Services in India should not always be an Army Medical Service man.

Indian Medical Service want of direct access to local government. Waste of man power in putting Indian Medical Service officers in billets where medical knowledge is not required.

Officers in civil should periodically do military training up to 20 years.

The cadre must be increased to allow of a reasonable amount of leave.

Study leave should be compulsory and count as duty. Pay requires raising all round. Want of sufficient military training, field ambulances, etc., officers in military employ should periodically be seconded to civil. Pensions might be rearranged. Officers are overburdened with office routine which prevents them from carrying out any original work. Scheme C is the only one which in any way meets the situation.

Q. 2.—Scheme C and the scheme suggested by Burma will I think meet the needs of the army in India. But I cannot say if it will meet with the approval of War Office.

Q. 3.—Yes, I think the proposed Burma scheme will attract a good stamp of recruit and meet the demands of professional opinion. But the service must be made attractive.

Q. 4.—A general loosening of the structures built in the past; this will show itself later if the service continues to be deprived of their European officers. Work has gone on, but the quality has suffered. Standard is lower than it was.

Q. 5.—We believe the scheme will satisfy the needs of the civil department and also produce a trained war reserve. No scheme can avoid any dislocation of ordinary peace machinery in a war on a large scale.

Q. 6.—Yes, the scheme if supplemented by private practitioners would give a large and efficient reserve.

Q. 7.—Yes, most certainly.

Q. 8.—The reserve on the civil side has been largely drawn on for military work and there would have been a great breakdown if the civil had not been employed.

Q. 9.—Recruitment by competitive examination and perhaps by the immediate appointment of suitably qualified officers who have done duty in the war.

Q. 10.—Study leave should be compulsory one year in twenty. It should count for duty for pay, leave and pension.

Q. 11.—There should be special research department and it should be recruited from the widest possible source.

Q. 12.—Has declined enormously in recent years.

Causes:—

Competition.

Official routine duties increased.

Frequent transfers.

Appropriation of fees by Government.

Question for service officers.

Q. 1.—Twenty-five years in military and five in civil.

Q. 2.—Personally I have no substantial cause for complaint.

Q. 3.—I have not personally had any friction with officers of the Royal Army Medical Corps.

Q. 4.—If British and Indian Medical Services were kept entirely separate, senior medical officers of stations should be done away with.

Q. 5.—Free interchange up to 20 years.

Special questions.

Q. 1.—The preference for European attendance which undoubtedly exists—is a combination of both factors, but the relative proportion of each factor varies greatly in different individuals. We are inclined to think that except in the case of European ladies the professional objection is stronger than the racial.

Q. 2.—I do not think that Europeans have been satisfied but they have been content to put up with war conditions and made the best of a bad lot. They have gone elsewhere for treatment. This could be better answered by non-professional people.

Q. 3.—As regards Indian Medical Service officers I cannot speak as I have seen only two young Indian Medical Service officers of recent years and them only for a few minutes.

Civil assistant surgeons.	} Have much improved in recent years.
Sub-assistant surgeons.	

Medical Stores Department.

Q. 1.—From local chemists' shops both by annual and emergent indent.

Q. 2.—With the civil surgeon.

If Government Medical Stores could be certain of supplying all articles required by civil surgeons and of good quality then it would be a convenience. I do not think there would be any objection to an arrangement which would ensure an equal standard in quality.

Q. 3.—The present arrangement of having an Indian Medical Service officer in charge part or whole-time is undesirable. The work is such that it could be carried out just as well by a non-professional man. I think the Government stores should be run on purely business lines.

The man in charge should have a knowledge of chemistry and also have a business training.

Subordinate medical staff are also unnecessary.

The whole of the stores might be handed over to some large firm at Home and they could be allowed a reasonable profit over wholesale trade prices.

Questions to be asked of officers regarding assistant surgeons and sub-assistant surgeons.

Q. 1.—The form of bond for sub-assistant surgeons in use in Burma on entering service is that prescribed by Government of India, Home Department (Medical) resolution no. 2—133-44, dated the 5th March 1889. The same form of bond was made applicable to civil

7 March 1919.]

Colonel P. C. H. STRICKLAND.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

assistant surgeons with some slight modifications by Government of India, Home Department (Medical) resolution no. 7—668-679, dated the 12th October 1891. This form of bond was modified further by the orders contained in Government of India, Home Department (Medical) resolution no. 647—659, dated the 2nd June 1903. The form of bond so modified was ordered to be made applicable to civil assistant surgeons (with modifications ordered in Government of India, Home Department (Medical) resolution no. 7—668-679, dated the 12th October 1891) by Government of India, Home Department endorsement no. 1220—1229, dated the 23rd October 1903.

No change has been made in the form of the bond during the war.

It is desirable that the bond should, in the form executed by civil sub-assistant surgeons, be made applicable to civil assistant surgeons also for these are times when it is very necessary to detail civil assistant surgeons on duties that partake of a military nature inasmuch as the civil assistant surgeons are required to serve with and render medical aid to troops on service, as with punitive expeditions and demonstrations through hostile tracts (which demonstrations are quasi-military in character).

It has been possible to compel only such sub-assistant surgeons as were under six years' service to proceed on military duty.

Q. 2.—Under legal advice it would no doubt be possible to make the bond renewable before the expiration of the first five years for another couple or three years at most. But such a measure may react unfavourably, especially in the case of civil sub-assistant surgeons in an already unpopular service. If civil assistant surgeons were also made liable for military duties, it is very possible that service would likewise become unpopular to these officers. The majority of civil sub-assistant surgeons and civil assistant surgeons marry early and being of Indian origin experience great difficulties in having their families cared for during their absence on military duties. These difficulties are greater in Burma than they would probably be if the men and their Indian families were in the provinces whence they have their origin.

Q. 3.—The conditions of the service in Burma are by no means satisfactory. Their position should be raised and should rank as jamadar upwards. Pay should be increased considerably considering the courses they have to go through.

Their training should be increased to 5 years so that those who desire can qualify at any of the universities. They should only be employed on professional work. There should be only one class of sub-assistant surgeons who should be required to perform civil or military duties as necessary.

Q. 4.—With the present cadre it is not possible to release many for military duties without seriously dislocating civil work. Inconvenience began to be experienced during recent years (1914—1918), immediately the members of civil sub-assistant surgeons and civil assistant surgeons surrendered for military duty exceeded the small percentages (25 per cent. in case of sub-assistant surgeons and 20 per cent. in case of civil assistant surgeons) allowed as reserves for leave and emergency purposes, and dislocation of the services both on the medical and sanitary services has become really serious within the last two years (1917-1918) inasmuch the Sanitary Department has been completely depleted of subordinate officers and all professional aid in combating epidemics by preventive measures has ceased to be rendered. On the medical side, hospitals and dispensaries have in many cases had to be closed, while duties have been doubled up at others. All leave except on medical certificate has been closed.

A much larger number of both sub-assistant surgeons and civil assistant surgeons could be employed with advantage if recruits could be obtained, but under present conditions the supply is altogether inadequate to meet demands.

Large tracts of country, especially in rural areas, are left entirely without medical aid both for want of men and the want of money. Travelling dispensaries and itinerating medical subordinates could be established in many parts of the country, besides hospitals and dispensaries being opened in the larger villages not on the high-roads of communication. Work at many of the existing institutions could also be made more congenial and satisfactory if more medical assistants (civil assistant surgeons or sub-assistant surgeons) could be employed at them, for under existing conditions whereby a civil assistant surgeon or a sub-assistant surgeon only is employed in charge of one institution, the men are required to be constantly on duty and do not have even one day's rest in seven ordinarily enjoyed by all other classes of government employés. In many places the men are isolated and are cut off altogether for weeks together from the outside world and have none of some similar standard of education with whom to associate and are not able to meet for months together any "professional brother." In most of such places all the work of treating and nursing cases devolves on the single individual in charge. Life in such conditions dulls and saps the energies, and it is surprising that the majority of the men retain sufficient interest or enthusiasm in their work as to be able to pass their periodic examinations.

The following statement shows the numbers of medical officers and subordinates surrendered from the civil department for military purposes during the recent war :—

Statement showing the distribution of medical officers and subordinates of the Burma Provincial establishment, on 1st January 1919.

Indian Medical Service.

Sanctioned cadre	33
Reserve 20 per cent.	6
Borne on rolls	39*
Leave	2
Military duty	26
Actually employed	30

Civil assistant surgeons.

Sanctioned number	44
Reserve 15 per cent.	7
Borne on rolls	50
Actually employed	39
On leave	1
Military duty	10*

Military assistant surgeons.

Sanctioned number	21
Reserve 15 per cent.	3
Sanitary appointments	15
Borne on rolls (both Sanitary and Medical)	33
Actually employed	2
Military duty (Medical)	17
Military duty (Sanitary)	14

Sub-assistant surgeons.

Sanctioned number	304
Reserve 25 per cent.	76
On rolls	388
Leave	23
Under suspension	1
Absent	1
On deputation (including foreign service)	8
Military duty	94
Actually employed	261

* Excludes 7 temporary assistant surgeons.

7 March 1919.]

Colonel P. C. H. STRICKLAND.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

The surrender of Indian Medical Service and Indian Medical Department officers (mainly military assistant surgeons in the case of the Indian Medical Department) necessitated civil assistant surgeons being taken from their ordinary positions as assistants to fill the gaps, caused in meeting the demands of the military department.

As regards the dislocation caused in the civil medical department by the surrender of military officers and assistant surgeons immediately after the outbreak of war and during the period immediately following, it is not easy to work this out in a statement showing the extent of the depletion, and the statement contrasting the numbers of officers in the various classes on 1st August 1914, and on the 1st January 1919 borne on our rolls, gives no idea whatever of the inconvenience caused.

On the 1st August 1914, we had no less than 44 Indian Medical Service officers on our lists, 14 of whom were at that time on leave. These were recalled and rejoined their appointments in Burma before the close of September 1914, and during the year following (*i.e.*, during 1915) no less than 30 of these officers were reverted to military duties; three others were reverted later but their places were subsequently filled by return of Major Saigol and Colonel Entrican. For some little while we were reduced to only 11 Indian Medical Service officers and it may be said we are practically in the same conditions since Colonel Hammond had to be granted leave and Colonel Sargent reverted for at present we have only:—

1. Colonel Strickland, Inspector-General of Civil Hospitals.
2. Colonel Williams, Sanitary Commissioner.
3. Major Knapp, Inspector-General of Prisons.
4. Colonel Barry.
5. Colonel Dee.
6. Colonel Pearce.
7. Colonel Castor.
8. Colonel Entrican.
9. Major Owens.
10. Major Saigol.
11. Major Harris.

Many appointments for Indian Medical Service officers had to be filled otherwise. This was affected in some cases by doubling up duties, thus the 2 civil surgeoncies, Rangoon, were combined; the superintendentship, Rangoon jail, combined with the appointment of assistant surgeon, Rangoon General Hospital; the superintendentship, Mandalay jail combined with that of civil surgeon, Mandalay, while the duties of Police Surgeon and Pathologist were divided between the Chemical Examiner and the Director, Pasteur Institute; the superintendentship, Irsein jail, was given to officers outside the department, the executive charge being vested in a whole-time police officer seconded for this purpose and the medical charge being held as a collateral charge by the railway medical officer. The two deputy sanitary commissionerships were left vacant; the Resident surgeons of the Rangoon General Hospital was filled by a civil assistant surgeon, so also the superintendentship of the Rangoon Lunatic Asylum; and the assistant medical superintendentship, Rangoon General Hospital, by an uncovenanted medical officer. So that of 35 sanctioned cadre appointments for Indian Medical Service officers no less than 10 (as shown above) were filled otherwise and the remaining 14 appointments had to be filled by 3 retired Indian Medical Service officers, 3 military assistant surgeons (one a retired officer), 5 by uncovenanted medical officers and 3 by civil assistant surgeons.

In normal times 12 military assistant surgeons would fill civil surgeoncies permanently, but as all except one military assistant surgeon (Hefferman)

was reverted to military duty, 12 such appointments had to be filled by civil assistant surgeons.

Besides these the 5 civil surgeoncies, ordinarily filled by uncovenanted medical officers and which became vacant in consequence of the uncovenanted medical officers being put into Indian Medical Service billets, had to be filled by civil assistant surgeons.

From what has been said above it will be seen in order to tide over difficulties civil assistant surgeons have been put into superior appointments to a very large extent. Thus, of the 38 actually on our rolls *plus* 2 on leave or 40 in all, 2 were in special appointments, *viz.*, superintendent, Lunatic Asylum, Rangoon, and Resident medical officer, Rangoon General Hospital, 20 in civil surgeoncies, 22 in all, leaving only 18 for their ordinary appointments and these were in the main employed at Mandalay (3) and Rangoon (about 11) general hospitals. Assistant surgeons were also employed at a few other stations such as Moulmein, Akyab, Bassein, Papun, Maymyo, Pazundung Female Dispensary, Myingyan, Yenangyung, Pyinmana. All other subordinate appointments for this class of officers were either left vacant or filled by sub-assistant surgeons.

From this cadre of civil assistant surgeons no less than 10 volunteered for military duties and were given temporary commissions in the Indian Medical Service. It was possible to spare these officers by promoting sub-assistant surgeons to the rank of civil assistant surgeons—8 permanent and 2 temporary, promotions being so made.

To tide over further depletions of the subordinate staff in consequence of demands made for medical men by the military department, Government had to be asked to specially sanction the entertainment of 20 civil assistant surgeons on a purely temporary basis.

The number of sub-assistant surgeons on our rolls just before and after the war, *i.e.*, in August 1914 and January 1919 were 338 and 388, respectively. In other words the number has increased by 50 during the four and half years of war though nominally there has been an increase, still in point of fact there has been a shortage and a serious shortage of sub-assistant surgeons during this period. 84 of our sub-assistant surgeons were surrendered for military duty which practically crippled the department rendering it impossible to find men for various duties for which sub-assistant surgeons are usually drawn upon. About 35 hospitals have had to be closed. Several charges have had to be doubled, *e.g.*, civil and police hospitals, Pyawbwe, civil and police hospitals, Magaung, civil hospitals at Thonze and Tharrawaddy, railway hospitals at Naba and Wuntho. Several new hospitals which have recently been completed and for which sub-assistant surgeons have been sanctioned had to remain unopened for want of sub-assistant surgeons, *e.g.*, Ponnagyun and Pauktaw in the Akyab district, Lewe in Yamethin district, Nagaputaw in the Bassein district and in Kyukpyu district. Hospitals for which two and sometimes three sub-assistant surgeons are sanctioned had to be carried on with one sub-assistant surgeon, *e.g.*, Akyab, Kyaukpyu, Papon, Bassein, Grabinyank, Shivebo, Myitkyina. Some hospitals had to be left in charge of compounders, *e.g.*, Myetkyo (P. W. D. dispensary) and other medical officers, *i.e.*, those outside Government employ, were entrusted with the charge of a few hospitals such as Kaubalu (railway sub-assistant surgeon) and Paungkhain (Dr. Barber of the A. B. Mission). Great difficulty has also been experienced in meeting the demands for sub-assistant surgeons for escort or column duty and the entertainment of a few temporary sub-assistant surgeons has not afforded the relief that was necessary. In some stations both a sub-assistant surgeon and an assistant surgeon used to be employed in normal times. During war, however either, the one or the other only could be employed, *e.g.*, Pyinimana, Papun, Paletwa, etc.

Q. 5.—It is certainly desirable to require civil assistant surgeons to sign agreements to serve in the military

7 March 1919.]

Colonel P. C. H. STRICKLAND.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

department in case of necessity. They should in this respect be treated the same as sub-assistant surgeons. No distinction as regards liability to military service should be made. All civil assistant surgeons should be liable for military duty when required up to the 15th year of service and this condition should be included in the bond.

Q. 6.—The ordinary medical requirements of the general population and of the State are not satisfactorily met by present arrangements. A much larger number of dispensaries, both travelling and stationary, are required. Existing institutions in isolated and out of the way or off beaten tracts should be served by itinerant medical assistants who would relieve the medical subordinates in charge periodically or join them for short intervals so as to relieve the monotony of existence and the constant strain of surroundings.

It is certainly desirable that there should be more control and supervision than is possible under existing conditions. At present, controlling and supervising officers are bound down to their headquarters by the multifarious duties imposed on them and which require their constant attention and prevent their getting away for any period during which they could exercise anything like efficient control or on provision of either efficient medical treatment or inculcate more proper methods among the medical staffs of out-lying hospitals and dispensaries. Little or nothing is done in the direction of treating or instructing in medical schools or colleges and sub-assistant surgeons and civil assistant surgeons generally have most hazy ideas on these subjects.

Q. 7.—The military sub-assistant surgeons will have to take the place of a resident medical officer and will have to be given rank; he will act as an assistant, outside the hospital he is employed in attending to the wives and families of Indian officers and men, etc. If they are more than required for military purposes they might be employed in the civil as a reserve.

Q. 8.—His training at present is not such as is required for military purposes. He should be

detailed to attend courses of instruction in field ambulances, etc.

Q. 9.—Am unable to answer this question.

Q. 10.—It would be a good thing for all civil assistant and sub-assistant surgeons to do duty in military hospitals whereby they would learn discipline and military routine. I think they might be used to good purpose by interchange, civil assistant and sub-assistant surgeons taking the duty of military sub-assistant surgeons.

Q. 11.—Pay should be much improved; they should be given the rank of jamadar, etc.; when on military service all sub-assistant surgeons should serve for a period on military side. Civil sub-assistant surgeon and resident medical officers be required to execute bond to serve for 15 years. Their period of medical curriculum should be extended to 5 years.

Q. 12.—As far as I know it is not necessary under present circumstances. He could be replaced by a non-professional trained man but this would necessitate a resident British medical officer always on duty day and night.

Q. 13.—In the civil department all military assistant surgeons were withdrawn except one for duty in military department.

Q. 14.—No, unless they are willing to join the civil department and be treated on the same footing as civil assistant surgeons but they must qualify first.

Q. 15.—The present class of men should not be recruited.

Q. 16.—If the standard of his medical education was raised and he qualifies at one of the universities he could be employed for civil and military duties as required. There should be no separate military class.

Q. 17.—He could be employed as an assistant surgeon in the civil department. He should be shown no preference in the matter of superior appointments and civil surgeoncies.

Q. 18.—As they are recommended to be qualified and form part of the civil assistant surgeons no separate conditions of service are required.

COLONEL STRICKLAND, called and examined.

His written statement represented his own views and those of some other officers whom he had consulted, but not those of the Government of Burma.

He had been in military service for more than 25 years and in civil for about 5 years only. He was in civil employ in the Central Provinces for two years.

The main inducement to young doctors to join the Indian Medical Service was the prospect of employment on the civil side, and that was one of the attractions, besides that of making a living, which led him to join the service, though he had been in civil for a very short time only. This was due to the fact that he did not like the Jail Department and had to revert to military duty.

The head of the Indian Medical Service, that is the Director General, should have direct access to the Government of India, and the service should not be under the Director of Medical Services in respect of the civil side.

There was one medical school in Rangoon which admitted 25 public and 25 private students every year. The number of pupils in the school at present was about 100. Last year the number of applicants for admission was more than could be admitted, there being 100 applicants while only 50 could be admitted. There was not much room for expansion and for admitting a larger number. The demand for admission was likely to go up gradually. A majority of the candidates seeking admission were Burmans. They were getting keener about the western system of medicine.

He objected to the amalgamation of British and Indian hospitals under one command, as under this arrangement a Royal Army Medical Corps officer having no knowledge of Indians was likely to be put in charge.

(General Hahir.) In making the suggestion, in his written statement, that the Government of India should be called upon to provide a European medical reserve for the British army in India, which was at present provided for by the United Kingdom, he recognised that there were a certain number in the Indian Medical Service in India who would be mobilised in the event of war. This number was, however, altogether insufficient and a considerable increase would be necessary.

It had been held that the Indian Medical Service had failed in the higher administrative grades in the war and that it had not the necessary military training. That was the reason why the Director of Medical Services was not chosen from this service. To remove this stigma it was necessary that Indian Medical Service officers should revert to military duty for periodical training. It would be well for Indian Medical Service officers to go to military and then to civil periodically. This would be to the advantage of both civil and military. Officers in civil employ should go back to military after four or five years for six months' training. This would not dislocate the civil. The military might lend their officers to the civil department. This would enhance the utility of both kinds of officers. The return of officers from civil employ would be a good training for them. The difficulties connected with the periodical transfers could easily be overcome. It would be a much simpler and more economical way than that of the formation of a unified corps. In fact he recommended that the Indian Medical Service should remain as at present provided the causes for discontent were removed.

He saw no objection to one organisation including clerks, store-keepers, bhisties, etc., sending out its men to British and Indian station hospitals.

7 March 1919.]

Colonel P. C. H. STRICKLAND.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

The post of senior medical officer should be done away with. The general consensus of opinion was that the existence of the senior medical officer caused a great deal of friction. He was always a British service officer and most of the Indian Medical Service officers in the station were very junior and all their orders passed through him. This officer could be abolished and orders sent through the senior Indian Medical Service officer. He would let the Indian Medical Service officer be independent of the Royal Army Medical Corps officer and would let both manage their own hospitals.

The present leave reserve in the Indian Medical Service was quite insufficient and required a large increase.

There was a great waste of man power in putting Indian Medical Service officers in offices where medical knowledge was not required. For instance they were placed in charge of Medical Store Depots where medical knowledge was not of much use, or were placed on jail duties which any body could perform.

The store depot might properly be put in charge of a business man who need only be a chemist.

Indian Medical Service officers were at present overburdened with a great amount of office work.

The war reserve as at present would not be sufficient to meet the requirements of ordinary wars such as frontier expeditions. No doubt it had not broken down on such occasions as in the past but this was managed by denying leave. Very few officers in civil employ could get leave. In the absence of the war reserve of 337 Indian Medical Service officers there would have been a great breakdown in the beginning of the war.

Military sub-assistant surgeons should be given Indian commissions. They must have some military training before entering on military duties and if properly trained they must be given commissioned rank. At present they were treated as mere clerks and performed only routine duties. They should be employed on professional work. They might be made resident medical officers or house physicians.

He advocated the amalgamation of civil and military sub-assistant surgeons into one interchangeable service. It would be better if they passed one examination, and all took military training.

There were very few private practitioners in Burma, there being only three or four Europeans practising in Rangoon.

Nursing in Indian station hospitals was not satisfactory and stood in need of reorganisation.

A colonel in the Indian Medical Service should get his maximum pension long before he earns it at present. Thirty years' service was too long and should be reduced to 25.

With reference to the two views regarding military assistant surgeons put before the Committee, namely, (1) to enhance his preliminary qualifications and give him opportunities for further professional training so as to enable him to acquire registrable qualifications, or (2) to abolish them altogether, he remarked that at present the military assistant surgeon acted as a sort of a local medical officer in a British station hospital, otherwise his duties were simply those of a clerk. If he were abolished a corresponding increase would have to be made in the number of British service officers. These assistant surgeons were useful in a way, and conducted a number of minor duties and were occasionally put in charge. It would be better, therefore, to accept the first suggestion. Such officers would have a chance of entering the Indian Medical Service. If civil and military assistant surgeons passed through the same tests they might be put on equal terms. At present civil assistant surgeons who were better qualified had a great cause of complaint as they had sometimes to work under military assistant surgeons.

He would retain the Indian Medical Service as at present with increase of pay and prospects and the other improvements suggested in his written statement.

(General Hendley.) There was a great difficulty in recruiting doctors in the subordinate service in Burma. This service was on the verge of a breakdown and a number of sub-assistant surgeons were getting sick. They were all doing double duties.

(Mr. Hignell.) The Burmans were coming in more and more for the medical profession as they were getting better educated. They would not, however, join it in appreciable numbers unless their pay and prospects were improved. Even if their pay and prospects were improved it would not immediately be possible to supply the medical needs of Burma by Burmans only. This was, however, the ideal kept in view. There was a large force of military police in Burma which was composed of Sikhs and other Indians, and it was essential that there should be Indian doctors for them. There was, however, a fair chance of the Burmans being able to carry on their own medical work within the next 10 or 20 years. The difficulty was that a large number of Burmans could not afford the expenses of education, but if they were given stipends they would join medical schools in large numbers.

MAJOR R. D. SAIGOL, I.M.S.

*Written statement.**Remarks regarding unification.*

1. There is no objection to unification if it is practicable without injury to the interests of the Indian Medical Service.

2. Any injury to the Indian Medical Service would be seriously deterrent to future enlistment of the class of officers who have hitherto entered the service.

3. That the name of the unified service should be such as would suggest its connection with India. There would, therefore, be no objection to its being named the Royal Indian Medical Corps.

4. The majority composing this corps should be men who have been elected for permanent service in India.

5. That unless the Royal Army Medical Corps entrance examination is of the same standard and identical to the Indian Medical Service, the officers of the Royal Army Medical Corps should not be admitted into the Indian Medical Corps as such admissions would lead to discontent amongst the Indian Medical Service officers especially amongst the Indians and Anglo-Indians who are at present debarred from entering the Royal Army Medical Corps.

Except as provided for in paragraph 5 above, Indian Medical Corps should consist entirely of officers recruit-

ed by an open competitive examination as now in force for the Indian Medical Service.

7. As the Royal Army Medical Corps officers are only birds of passage and come to India only for a tour of duty, they should not be given civil appointments which should be reserved solely for officers electing permanent employment in India.

8. That the unified service should not in any way debar eligible Indians or Anglo-Indians who may pass the required tests.

9. That the interest of Indians and Anglo-Indians should be suitably represented by a member of their own class on the recruitment board.

10. Nominated Indians and Anglo-Indians with Indian qualifications who have not enough private means should be given scholarships to enable them to qualify for admission.

11. There should be no ill defined auxiliary service as has been suggested in one of the schemes. Any racial distinction would not conduce to amicable relationship and may impose undue harshness on Indians and Anglo-Indians. If practicable a scheme should be devised without any irritating references to racial distinctions.

12. As to what scheme should be actually adopted, I am of opinion that this cannot be determined within

7 March 1919.]

Major R. D. SAIGOL.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

the short time that has been allowed to us. The details should be worked out by a committee on which all interests, i.e., European and Indian should be duly represented.

Questions of service officers.

1. Five years in military including six months in a British station hospital and two years in charge of the Medical Store Depot, Rangoon, 11 years in civil department, Burma.

2. Yes, that the claims of Indians are ignored. I have not been treated with the same consideration in the matter of appointments as Europeans officers have.

3. Yes. The two services are not on friendly terms. There is considerable jealousy and consequent friction.

4. (a) Regarding the two services Royal Army Medical Corps and Indian Medical Service the proposed unification should aim at removing causes of friction as far as possible.

(b) Regarding grievances of Indian Medical Service itself.

(i) Whichever scheme is adopted it should have no irritating references to racial distinctions. All subjects of His Majesty irrespective of their caste, colour or creed should receive equal treatment provided of course they are suitably qualified. At present an appointment requiring special qualifications may be given to an European officer with no special qualifications and all because the Indian is said to be wanting in administrative capacity, etc. These opinions are expressed by people who are biased and benefit by the Indians being kept back for it will not be to the advantage of the European officer if he were to admit that Indians were equally capable officers. I have known instances where an European officer has not even been spoken to for actions over which an Indian officer has been censured. To form a true opinion of Indian character and capabilities, the judges should be absolute outsiders, i.e., men who have no interest in the particular service directly or indirectly; a board of capable Indians on which European officers should sit, would be considered impartial.

I have worked in England and foreign countries with eminent professional men who have expressed their opinion as to my work and capabilities in terms quite different to what I have heard European Indian Medical Service officers say.

(ii) Service should be made more attractive—better pay, better leave rules, abolition of all restrictions regarding private practice are some of the points requiring attention.

Special questions.

1. In my opinion the desire on the part of European members to be treated by men of their own nationality is due to fellow feeling and with a view to have more members of their own kind for social purposes.

Two things count more than racial distinctions :—

(1) The fees—often in a district the sub-assistant surgeon has the bigger practice among Europeans and is much more popular even among the ladies because his fees are lower and for minor ailments he is just as good as the European doctor.

(2) Professional merit usually commands respect irrespective of nationality.

2. So far as I have known they have all been very satisfied with the substitutes. They have not made many complaints (if any) regarding the work of the assistant surgeons promoted to civil surgeons. Some have actually told me that they are excellent; yet the opinion of the European Indian Medical Service officers is "that European members have made the best of war conditions"—a very non-committal sort of opinion which I do not consider is fair to the men. It is equal to taking the gilt off the ginger-bread.

Medical Stores Department.

I have held the appointment of the Medical Store-keeper to Government of Burma for nearly two years.

3. The present arrangement where an Indian Medical Service officer is in part or whole-time charge of a Medical Store Depot is undesirable. The work is such that can be carried out much more efficiently and cheaply by non-professional men. One with business training and knowledge of chemistry would make an admirable manager.

The stores should be run by a man trained on business lines as a business proposition and not as a Government Department. All subordinate medical staff is at present being wasted to do the work which compounders can do.

Perhaps it would be cheaper to give the contract to some big firm at Home and allow them sufficient margin for expenses and reasonable profit over wholesale Home trade prices.

Assistant and sub-assistant surgeons.

5. An agreement to serve in military (if required) up till the 15th year of service is desirable.

7. A military sub-assistant surgeon in my opinion serves the purpose of a clerk, compounder and a dresser, all of which could be performed by non-professional men. Sub-assistant surgeons should be employed solely on professional work and given every opportunity of improving themselves.

8. Training is sufficient but they get no opportunity of practical work. The appointments should be interchangeable with civil sub-assistant surgeon and no one should be kept in one appointment for more than three years.

9. Knows the Army Regulations and can do the routine work but is not to be compared in professional efficiency to a civil sub-assistant surgeon.

10. Yes as assistants—but duties of a non-professional nature should not be required of them.

11. Civil and military appointments should be interchangeable so that all the members may be fully trained in professional and military duties.

12. Military assistant surgeons in a military hospital perform the same duties as a sub-assistant surgeon in an Indian troops' hospital. The most senior, usually with an honorary rank, is practically the head clerk. Junior members do all the duties of compounders and dressers, clerks and assistants, all of which could be equally efficiently performed by non-professional men, i.e., by employment of clerks, compounders and dressers, etc. The cadre of the Royal Army Medical Corps need not be increased if military assistant surgeons are abolished; usually there are so many Royal Army Medical Corps officers in a hospital that each of them does not have more than a few hours' work a day. Royal Army Medical Corps officers should perform all the duties themselves, including the duties of resident medical officer, as they do in the United Kingdom.

13. Only a few military assistant surgeons were left in Burma in civil. They did not relieve the demand for medical men to any great extent.

14. Military assistant surgeons should first be made to qualify the same as civil assistant surgeons and then take their chance alongside them. There should be no difference between the two classes.

15. Yes, the recruitment of present class of men should cease at once. In the interests of the men themselves, if nothing else, Government should not encourage the growth of unqualified practitioners.

16. I am not in favour of military assistant surgeons as a separate class. They must be educated and made to qualify the same as a civil assistant surgeon has to do and then may be employed in the civil or military as required.

17. As assistant surgeons they should be liable for both civil and military duty. And in the matter of superior appointments he should be treated the same as a civil assistant surgeon.

7 March 1919.]

Major R. D. SAIGOL.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

18. All military assistant surgeons who wish to qualify should be given necessary leave and required to obtain a university qualification at any of the Indian colleges. Those who fail to do so should not receive any leave allowance and should be made to retire.

Honorary commissions should not be given to them unless they are in all respects to be regarded as equal to officers of the Royal Army Medical Corps of their own grade. They should not be subordinate to the Royal Army Medical Corps officer of a lower rank.

MAJOR R. D. SAIGOL, called and examined.

(President.) He had been five years in military, including 6 months in a British station hospital and two years in charge of the Medical Store Depot at Rangoon. In addition he had been 11 years in the civil department in Burma. He was now ophthalmic surgeon in Rangoon. He was not satisfied with the way in which he had been treated and he put this down to racial feeling. He was better qualified than most officers but his qualifications were overlooked. He was an F. R. C. S. He had specialised in Great Britain and on the continent in diseases of the eyes, ears, nose and throat. He had been in Germany and Austria. He had spent two months in Berlin and six months in Vienna. In January 1914 he went to Austria and from there he went to Berlin. He left Berlin in August—shortly before the outbreak of war. He had worked in England and foreign countries with eminent professional men and they had formed a very high opinion as to his work and capabilities. This opinion on his work was not held by European Indian Medical Service officers, although he had worked side by side with them. He had sent to the Government of India copies of his testimonials in order to get his name registered for an appointment on the Imperial list of specialists.

He was a native of Delhi and he belonged to the Khatri caste.

(General Hehir.) He was in favour of granting scholarships to go to England to selected Indians and Anglo-Indians. He would make examinations within the reach of all. He would not make it incumbent on the holders of scholarships to join the Indian Medical Service. Even if they did not join the Indian Medical Service, they would at least be better educated, and they would form a useful war reserve.

He advocated the abolition of the military assistant surgeon altogether. There should be no unqualified men in India. The Government should not encourage unqualified students. He pointed out that all other countries had one standard of education and that India should not be different in this respect. He would give the military assistant surgeon more professional work to do. He would appoint him as a sort of a resident medical officer.

(Lieutenant-Colonel Bhala Nauth.) He had taken his special courses of instruction on the advice of the late Sir P. Lukis, who had promised him that, if he did

these courses in Berlin and Vienna, he would be given a specialist's appointment in either Calcutta or Bombay. After he had completed his course he had asked for his name to be registered on the Imperial list. He brought to the notice of the Committee that his claims had been overlooked and that Colonel Maynard had been appointed. He pointed out that he had been put to a great deal of expense and trouble and had spent 18 months of his leave in specialising, but it was all to no purpose as his claims had been forgotten.

He knew of no cases where Europeans objected to being treated by Indian Indian Medical Service officers. He had been six months in charge of a British station hospital at Wellington, and his experience has been that all the soldiers preferred to be treated by an Indian Medical Service officer. He had not heard of any complaints about Indian Medical Service officers. He did not think that the Indian Medical Service contained any low class Indians. Most of those who entered the service were Punjabis, Brahmins, Parsees and a few Mahomedans and Hindus.

He did not agree with the opinion that Indian Indian Medical Service officers were incapable of filling professorships in medical colleges in Calcutta. Personally he was of opinion that they were never given opportunities for such work. He knew of cases where Europeans had been appointed who had absolutely no qualifications for the appointment. In such cases they were encouraged in every way possible to acquire the knowledge necessary. He was expected to know everything beforehand, while others were given opportunities for learning after they had been appointed. The appointments were first made and then the officers appointed were told to go to England and study. He thought this was very unjust.

He was in favour of private practitioners joining the war reserve, but they should all hold registrable qualifications. Private practitioners would be willing to serve in the army if they received sympathetic treatment.

(General Giffard.) He was opposed to the idea of appointing ill-qualified medical men in rural areas and villages. He suggested that the minimum qualifications for men appointed in rural area should be the licentiate in medicine and surgery. As villages and rural areas will not have the means to pay for qualified men the Government will have to assist.

CIVIL ASSISTANT SURGEON M. L. KUNDU, M.B. (Calcutta), officiating Resident Surgeon, General Hospital, Rangoon.

*Written statement.**Questions for civil assistant surgeons.*

1. If the Government decide on an unification of the medical services in India, would you be prepared to serve with Indian troops and in Indian station hospitals?

2. Are you satisfied with your existing pension rules?

3. Are you satisfied with the provision that is made by Government or by yourselves for widows and orphans of military assistant surgeons?

4. Does any specific disability exist in your department which needs the attention of this Committee (pay and allowances are not to be discussed)?

5. Do you think that the civil assistant surgeon's department at the present time attracts or does not

attract the best of that class of young men which it might attract in altered circumstances?

6. Have you any suggestions to make regarding the present method of recruiting for your service?

7. Should the local Government decide to throw open civil appointments to a larger number of military assistant surgeons, do you think such appointments would be popular and how would they affect your service?

8. If Government propose that all civil assistant surgeons should undergo a course of military training and be called to military employment in case of war, would this be popular in your department and would it affect recruiting?

7 March 1919.]

Civil Assistant Surgeon M. L. KUNDU.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

Copy of a letter from M. L. KUNDU, M.B., Honorary Secretary to the Burma Assistant Surgeons' Association, General Hospital, Rangoon, to the Inspector-General of Civil Hospitals, Burma, Rangoon, dated the 27th February 1919.

With reference to letter no. 01873—15-E.-11, dated the 22nd February 1919, we beg to forward the following replies to the questions:—

For question no. 1.—We as yet do not know in detail what unification is proposed in the case of civil and military assistant surgeons. As matters stand at present we are quite prepared to serve with the Indian troops and in the Indian station hospitals, if we are granted commissioned rank as given to the members of our service who volunteered for military duty and were taken as temporary Indian Medical Service officers.

For question no. 2.—The medical officer has to work practically without a holiday throughout the year. The duties are strenuous and few outlive the thirty years' service to enjoy pension. We consider that one should be permitted to retire on full pension after 25 years' total service and if invalidated on medical grounds, after 20 years' total service. When on military duty, wound pension, family pension and other similar privileges should be granted on the same lines as applicable to other commissioned officers.

Article 408, Civil Service Regulations, imposes a very heavy penalty on Indians. A European officer is allowed to count as service towards pension in a total service of 25 years, 3 years of long leave which he may avail himself of and spend in Europe (his native country), whereas an Indian having 25 years' total service if he takes 3 years' long leave and spends it in India (his native country) is allowed to count only one year of the leave as service for pension. This means that he is penalised to the extent of two years and before retiring would have to put in 2 years' more active service before he could earn his full pension.

For question no. 3.—We are not in a position to answer the question as the conditions are unknown to us.

For question no. 4.—These specific disabilities are many:—

The principal disability that our service suffers from, as at present constituted, is that we can never aspire to admission into the superior medical service, in spite of obtaining any higher qualifications or possessing sufficient ability. A few civil surgeoncies of very unimportant nature and in remote localities, are thrown open to us, to which only a few of us can aspire at the very last stage of our service. Our qualifications with a few exceptions are registrable in the United Kingdom and professionally we are in no way inferior to officers of the superior services. The scheme formulated by us which affords us opening into the superior service has been already submitted to the Inspector-General of Civil Hospitals, Burma.

The other disabilities which we experience in Burma have all been presented before the Inspector-General of Civil Hospitals at a deputation from the assistant surgeons on the 20th February 1919 and in a written memorandum as well. The change of designation to provincial medical service and throwing open of 50 per cent. of superior service posts to our cadre should be given effect to.

For question no. 5.—The existing members of our service in Burma and as far as we know those in India, are probably the best type of medical graduates that Indian Universities produce. It is not the pay and prospects of the assistant surgeons' service that attracts

but the fact that there is no better alternative left to us than to enter Government service which alone confers an opportunity in India to get sufficient practical experience by working in the large hospitals. The public are still ignorant of the relative qualifications between the Indian medical graduates and those in superior appointments, owing to every high post being apportioned to a particular class of service. Except in large cities there is no scope for Indian or Burman talent. Because, however, qualified an Indian or Burman doctor may be the subordinate position to which he has been relegated for ages makes the public think that he is less efficient. It is pecuniary circumstances that force the Indian graduate to join the civil assistant surgeons' cadre and if sufficient money is forthcoming, no decent medical graduates will ever think of joining the civil assistant surgeons' class, in preference to prosecuting studies in England and getting a commission in the Indian Medical Service. If circumstances are altered for the better, there is no doubt that it will attract and retain the best of young men trained locally.

For question no. 6.—There is no special method of recruitment in Burma. If the superior service is opened to our class, a competitive entrance examination may be held in each province.

For question no. 7.—The large number of civil surgeoncies and other superior posts that are already open to military assistant surgeons in Burma, stands in the way of our promotions more than anything else. Nineteen civil surgeoncies not apportioned to Indian Medical Service officers and deputy superintendships of Rangoon Jail and Lunatic Asylum were held by them at the commencement of war, whereas we had only four civil surgeoncies offered to us. The disparity is already ridiculously great and any further encroachment will prove most unpopular with us. We consider that only those military assistant surgeons who have a registrable qualification should be given civil surgeoncies or posts held by civil assistant surgeons. Furthermore, although the military assistant surgeons have no professional registrable qualifications similar to those held by civil assistant surgeons, they are given a larger number and better civil surgeoncies than are given to civil assistant surgeons, and in addition they rise to honorary military rank which confers on them considerable advantages and raises them in the opinion of the Government officials and the general public. As long as civil surgeoncies are given to military assistant surgeons, instances will occur in which civil assistant surgeons with good professional qualifications will be required to serve under military assistant surgeons who have practically no qualifications. This state of affairs is far from satisfactory and will be accentuated if more civil surgeoncies are given to military assistant surgeons. If the position were reversed and military assistant surgeons had to serve under civil assistant surgeons, they would no doubt howl, but with less cause so long as their professional qualifications are poor and unrecognised in the United Kingdom.

For question no. 8.—The assistant surgeons are quite prepared and willing to be liable for military service in case of necessity if the conditions in the service are improved. It will not affect recruitment of the best type of candidates. We are willing to bear our share of responsibilities but not without its privileges.

CIVIL ASSISTANT SURGEON M. L. KUNDU, called and examined.

(President.) He had been educated in Calcutta. He was a Hindu of the Baidya caste. He had completed nearly 10 years in Government service. One of the grievances of the assistant surgeons was that they could never gain admission into the superior medical service.

He was officiating in the appointment of an Indian Medical Service officer and his present pay was Rs. 700 consolidated.

This was only as a temporary war measure. His grade pay was only Rs. 300. If the Indian Medical Service officer came back he would have to revert to his old appointment. He was not allowed to take up private practice. He had not been asked to go on war service nor did he volunteer. He was medically unfit on account of his eyesight.

7 March 1919.]

Lieutenant-Colonel Sir LEONARD ROGERS.

(The schemes and questions referred to by witnesses are contained in Volume III.)

LIEUTENANT-COLONEL SIR LEONARD ROGERS, KT., C.I.E., F.R.S., M.D., F.R.C.P., F.R.C.S., I.M.S.

Written statement.

I consider scheme A unsuitable. It would involve administration to a considerable extent from London with all its drawbacks, while India is large and important enough to have its own medical service.

Scheme B furnishes the basis of a workable plan and seems to be preferable to any of the others, so the following remarks will be based on it and suggest some points which its study has raised in my mind, purely from the civil point of view as I have had no military experience for 28 years.

Paragraph 2.—Ratio per mille.—In my early military days the work was ridiculously light and quite insufficient to satisfy any man with keen professional instincts. The raising of the ratio per mille from 1·2 to 3 will presumably make it lighter still, so I doubt if the military part of the combined service will by itself attract the best type of men. The old attractions of the civil side will, therefore, have to be maintained and if possible improved from their present greatly decreased prospects.

Paragraph 3.—More officers were in civil employ.—From the figures given in paragraphs 4 and 13 I estimate that hitherto about 64 per cent. of Indian Medical Service officers were in civil employ, while in the combined service in future only 40 per cent. will be on the civil side. As the civil branch has hitherto been the great attraction to the best qualified men, it is clear that the number of civil appointments should be increased both to increase the attractions of the service as a whole and to raise the military reserve in proportion to the increase of the military Indian Medical Service cadre. Larger staffs and more specialist appointments are required to bring medical colleges up-to-date, while further research workers and also whole-time pathologists for all the larger hospitals are wanted to enable the clinical staff to have the advantages of microscopical examinations in all fever and dysentery cases and many other modern diagnostic methods. Such new posts should be reserved for the new Indian Medical Service cadre. Unless the civil posts are materially increased, officers will not obtain civil employ until so late in their service that their professional keenness will often have worn off to a large extent, and the best men will either resign their commissions or become discontented, to the detriment of future recruiting.

Paragraphs 3 and 4.—Royal Army Medical Corps Officers.—In taking a large number of Royal Army Medical Corps officers into the unified Indian service it must not be forgotten that unless special precautions are taken the very rapid promotion so many of them have received during the war as compared with Indian Medical Service men will in a short time result in only Royal Army Medical Corps men reaching the higher administrative ranks. Any such officers admitted to the new Indian service should take the rank according to the dates of passing into the service, or if this is not possible they should only be eligible for a certain number of administrative posts in proportion to their numbers.

Paragraph 8.—The Director, Medical Services.—The Director should always, not only ordinarily, be appointed from the unified service. The exceedingly remote possibility of an Army Medical Service man from England, with comparatively little Indian experience, being better than every single man in the large unified Indian Medical Service is so problematical as not to be worth a moment's consideration beside the deep dissatisfaction such a procedure would inevitably cause to the whole of the members of the slighted Indian service.

Paragraph 12.—I agree that officers remaining permanently in civil employ should not be eligible for promotion to military administrative posts.

Paragraph 13.—Residuary appointments in civil employ.—1. *Medical College Professorships.*—There can be no question that many of the ablest men in the Indian Medical Service were originally attracted to it by the

possibility of obtaining a professorship in one of the medical colleges, and the general average of the candidates was raised considerably by that attraction. Now that the ordinary civil surgeoncies are less attractive than formerly, it is very essential that the professorships should continue to be reserved for Indian Medical Service officers, as recommended by the Public Services Commission. At the present time Indians, in addition, to holding all the professorships at the Belgachia Medical College and all the equally attractive teaching posts of the Campbell Medical School hold three of the Medical College professorships permanently, and one temporarily, leaving only eight to Indian Medical Service officers, or about one-third of such teaching posts in Calcutta; yet the Indians are still clamouring for more of the Medical College posts. Any further concessions to them in this respect will be gravely detrimental to the recruiting attractions of the Indian Medical Service. On the other hand, some reforms are necessary to make the professorships purely specialist posts, for at the present time all the clinical appointments at the Calcutta Medical College, except the Professor of Medicine combined with the Principalship, carry the right of general practice, and we find even professors of surgery, ophthalmology and materia medica doing midwifery and general practice of all forms, although there are nearly one thousand students in the College, which is thus far larger than the great majority of medical schools in Great Britain and Ireland with specialist staffs. This subject was raised by the Government of India some years ago and discussed by the Calcutta Medical College Council, who agreed that it was wrong in principle, but rightly pointed out that to remedy it the professors must be relieved of the duties of Presidency Surgeons' work of attending Government servants. The pay will have to be much enhanced, as it does not now cover the actual cost of living in a suitable position in Calcutta, while limitation of private work to consulting practice will greatly reduce the value of the posts, although I think pure consultants will get more consulting work than the present general practitioner professors.

2. *Imperial Cadre for College Professorships.*—The present limited provincial civil cadres cannot be expected to furnish the best type of consultant specialist professors, so there should be an Imperial cadre to supply them, as in the case of the bacteriological, or as it should be called medical research department. Local provincial officers should have no special claim on the local college professorships, which should be filled by the best men available in the whole service, those with the necessary higher qualifications being eligible to put their names down for the special line they wish to adopt. Similarly the research professorships of the Schools of Tropical Medicine should be filled from the Imperial Medical Research department.

Paragraph 17.—Advisory Board.—A strong Advisory Board should make recommendations for all professorships on the lines of paragraph 17. I also agree that a Military Advisory Board should select for administrative grades, and the Director General should also have the help of a Board in making promotions to civil administrative posts, as with the enlarged cadre suggested only a small proportion of the service will ever reach the administrative grades, and the best men should be selected. The present system of promoting almost every officer by seniority results too often in only those who entered exceptionally young, and consequently nearly always without having had time to take the higher medical qualifications, obtaining promotion, while the more highly qualified men, who entered at a later age, are in the Bengal list nearly always run out by age.

Paragraph 19.—Medical Staff College.—I presume that this will not compete in the way of post-graduate medical teaching with the Schools of Tropical Medicine.

7 March 1919.]

Lieutenant-Colonel Sir LEONARD ROGERS.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

Paragraph 16.—I agree that no Indian civil medical service is advisable. The necessity of supplying a military reserve precludes this, while a purely civil service would sink to the level of the police man under the non-scientific thumb of the Indian Civil Service men, including junior magistrate often with a third of the civil surgeon's Indian service. That is not a position which will attract scientific medical men.

The necessity of granting retiring gratuities in early years of service before a pension is earned in view of the uncertainties of the political future.—Apart from the uncertain political future of India I believe it will be possible to attract a useful type of medical man to the proposed unified medical service in India on the lines of scheme B with the foregoing modifications. The proposal of the Chelmsford-Montagu's scheme to place the civil medical department under an Indian minister, and the further proposal to recast the constitution every ten years or so, introduces a degree of uncertainty in the careers of men entering a service with the prospect of spending their life in it, as they can form no idea of what their position will be as regards the more attractive

civil work at least, in the future except that it is almost certain to be altered for the worse. This uncertainty will militate more against recruitment than any other factor when it is realized in Great Britain. It will, therefore, be necessary to allow all officers, including those already in the service, to retire at stated periods of their early service, before they become pensionable, on liberal gratuities, which would enable them to buy a practice or partnership at Home, as is already in force in the Naval medical service. They should have this option every four or five years of their service. The frequency with which officers availed themselves of this right would be a very valuable guide to the Government regarding the popularity or otherwise of the service, which should allow them to gauge any discontent in time to enable wise statesmen to take the necessary steps to remove the causes of such discontent before the service is again brought to the present position of being unable to recruit the class of men whom it used not long ago to command, which only very liberal and expensive remedies will now relieve.

LIEUTENANT-COLONEL SIR LEONARD ROGERS, Kt., Calcutta, called and examined.

(President.) He had read all the schemes very hurriedly and it appeared to him that scheme B was the best.

His qualifications were M.D., B.S. (Lond.), F.R.C.P., F.R.C.S. and F.R.M.C. He was at present Professor of Pathology in the Medical College. He had been in the same college for the last 19 years with but slight interruptions.

He was arranging for the new School of Tropical Medicine. The school would be opened in June 1920.

He was very anxious that the medical colleges should have larger staffs and more specialist appointments. Further, research workers and whole-time pathologists would be required for larger hospitals. He suggested these points as indicating the lines on which the civil branch would have to be strengthened under scheme B.

He drew attention to the difficulties in the way of taking a large number of Royal Army Medical Corps officers into the unified medical service. During the war, the Royal Army Medical Corps had received very rapid promotions. If special care was not taken, the time would soon be reached when every military administrative post would be filled by Royal Army Medical Corps officer. This would not be fair to the Indian Medical Service.

In his opinion many of the ablest men in the Indian Medical Service were attracted originally by the prospect of obtaining professorships in one of the medical colleges and the rise in the general average of the candidates was mainly due to that. If the service was to attract very able candidates, the professorships in the colleges should be reserved for Indian Medical Service men as recommended by the Public Services Commission. At present Indians held all the professorships in the Belgachia Medical College and also all the teaching posts in the Campbell Medical School. In addition to these, they held 4 out of 12 professorships in the Government Medical College. If the recruitment of high class candidates was to be continued, the interests of the Indian Medical Service ought to be safeguarded and no more Indians should be appointed to these professorships.

The professors as a rule should be specialists in their subjects and should not be asked to do anything which did not concern their subjects. The smallest hospital in London had a specialist staff. The smaller towns had men who generally practised as well. In modern American schools and colleges, they had specialist staffs and Calcutta with a population of over a million inhabitants should be able to support a staff of specialists. The creation of such a staff would strengthen the position of officers.

The professors ought to be relieved of the work of attending on Government officials. At present no Indian Medical Service officer could live on his pay in Calcutta.

(General Cree.) He was not in favour of a purely civil medical service. There would be very little competition for it in England, more especially in view of what he had said in the last paragraph of his written statement.

(President.) He laid great stress on the necessity of granting gratuities in early years of service before pension was earned in view of the uncertain political future of India.

He agreed with the opinion expressed by Lieutenant-Colonel Calvert that the overcrowding of the medical college was due to the increasing predilection of young Indians for a medical professional career. The number of applicants clamouring for admission into the medical college was so large that they could always select men with science qualifications. That was a great advantage. On the other hand, the clinical teaching both in surgery and gynaecology was very deficient owing to the inadequate staff.

The prospects of independent European medical practitioners were better now than 10 years ago. He knew of a partnership concern where two persons had made a real fortune in the course of 10 years. There were more Europeans in Calcutta and the European medical practitioners were getting fuller work. The advantage with these men was that they were permanently residing in Calcutta whereas the Indian Medical Service were not. The practice of these independent medical practitioners was more with Europeans than with Indians. The Indian Medical Service men were getting more practice with Indians, as the Indian students and the Indian public knew all the professors in the Medical College. At present the difficulty was that that officer coming to Calcutta to officiate for a fortnight or a month in any one of the clinical appointments could not live on their pay, and they did not get sufficient practice even to live without getting into debt. They must be given better pay and be allowed only consulting practice. This would enable them to devote more of their time to teaching and reading literature on the subject in which they were interested.

The practice of Indian Medical Service officers among Indians was not declining. Some years ago during the Swadeshi movement, certain Indian practitioners refused to call in Indian Medical Service men but that passed off. Moreover Calcutta was a place where people from all parts of India had congregated.

(General Hehir.) The reforms scheme contemplated the placing of the civil medical service under an Indian minister and it was further proposed to recast the constitution every 10 years or so. This introduced a great deal of uncertainty in the careers of men entering the service. So he would advocate the granting of gratuities for officers who desired to retire at certain stated periods. The advantage would be that it would

7 March 1919.]

Lieutenant-Colonel Sir LEONARD ROGERS.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

give the officers concerned an opportunity of considering their position at regular intervals.

At present research workers were not paid sufficiently to attract the best class of men. Only the very best men were required for research and they should be paid much more and asked to give up all idea of practice.

The medical education of military assistant surgeons was not of the class it should be. As Government required men, the military assistant surgeons had to be passed whether they were qualified or not. They did not take sufficient interest in their studies, as their appointments were assured. With the introduction of Government examinations fixing a definite standard, he hoped that the position would be improved.

(General Hendley.) The School of Tropical Medicine was largely supported by merchants and by influential Indians. These merchants had given money only for additional wholetime research appointments. The Government of India also had promised to give a sum of Rs. 20,000 a year. The only thing they insisted upon was that the professor appointed should be a European. In the school there would be about 5 or 6 professorships held by Indian Medical Service officers. He considered that it would be the most economical and most satisfactory way of filling up these appointments for the reason that the professors selected would be the "pick" of the Bacteriological Department.

(Sir T. Nariman.) The permanent professorships held by Indians in the Calcutta Medical College were:—

- (1) Professor of Anatomy.
- (2) Professor of Biology which was sanctioned as an Indian appointment.
- (3) Professor of Physics, and
- (4) Professor of Chemistry.

What he had said above should not be taken to mean that he was very nervous about the scheme outlined in the Montagu-Chelmsford report. He was perfectly ready to give it a trial. Indeed he would be very pleased if it was a success. But he was speaking all the while from the point of view of recruitment. He was convinced that it would affect recruitment adversely unless such safeguards as those he had suggested were provided.

The Public Services Commission had recommended that all the clinical appointments excepting two or three should be reserved for Indian Medical Service officers. When the question about the holding of scientific chairs by Indian Medical Service officers came up for discussion before the Public Services Commission, he held that so long as these posts were intended for Indian Medical Service officers, there would be no dearth of candidates competent to fill them. He instanced the cases of Professors of Botany and of the head of the botanical gardens who were a complete success and who later became fellows of the Royal Society.

The one difficulty that was often experienced in filling up short leave vacancies was that though there were good men available in the mufassil, they could not be transferred to Calcutta owing to their low pay. In fact he knew of a case where a man in the mufassil who had acted twice as Professor of Surgery in the Medical College refused to come the third time because he said that every time he had been in Calcutta he had lost money and that he could not afford to lose any more. To get over this difficulty he suggested the institution of some local allowances, which need not necessarily be the same for all cities.

(General Giffard.) The civil needs of India were bound to increase every year. These needs could be met only by the creation of a large number of sanitary appointments. This had nothing to do with the increases in the staffs of medical colleges and research workers which he had advocated in his written statement. He thought that Indians who passed out of the School of Tropical Medicine or the Hygiene Institute could be appointed to these posts. Recruitment for this kind of work could not be made satisfactorily in England, as holders of the D. P. H. of British Universities knew nothing of tropical diseases. These men could conveniently be grouped under one service and be given a better status.

He would not object to taking brilliant assistant surgeons into the Indian Medical Service.

At present large numbers of men holding the degree of M.B. were being turned out. What was wanted most was a large number of sub-assistant surgeons who would go into the villages.

10 March 1919.]

Lieutenant-Colonel F. E. SWINTON.

*(The schemes and questions referred to by witnesses are contained in Volume III.)***At Madras, Monday, 10th March 1919.**

PRESENT:

S. R. HIGNELL, Esq., C.I.E., I.C.S. (Presiding).

MAJOR-GENERAL G. CREE, C.B., C.M.G., A.M.S.

MAJOR-GENERAL P. HEHIR, C.B., C.M.G., C.I.E., I.M.S.

MAJOR-GENERAL H. HENDLEY, K.H.S., I.M.S.

THE HON'BLE MAJOR-GENERAL G. G. GIFFARD, C.S.I., I.M.S.

LIEUTENANT-COLONEL A. SHAIRP, C.M.G., Indian Army.

MAJOR M. T. CRAMER-ROBERTS, D.S.O., Indian Army.

and, as co-opted member LIEUTENANT-COLONEL H. ROSS, O.B.E., I.M.S.

MAJOR A. A. McNEIGHT, I.M.S. (Secretary).

LIEUTENANT-COLONEL F. E. SWINTON, C.I.E., I.M.S., Medical Storekeeper to Government of Madras.

Written statement.

Answers to questions for service officers.

Q. 1.—How long have you been in military service and how long in civil service?

A.—My whole service has been in "Military," as follows:—

Regimental duty 3 years.

Personal Assistant to Principal Medical Officer, Bombay Command, 5½ years.

Medical Storekeeper to Government, Bombay, Calcutta and Madras, 17 years (with 8 months as Deputy Director General, Indian Medical Service, which is technically "Civil" but I had nothing to do with civil work. I controlled the (Military) Medical Stores Department.

Q. 2.—Have you any substantial cause for complaint or discontent?

A.—(a) I have many substantial causes for complaint and for deep discontent, commencing with the fact that up to 18 months before I joined at Netley, the Indian Medical Service got their commissions on entering Netley. I got mine on leaving and so have lost 4 months throughout my service at every step. After some years this injustice was recognized and altered by a return to former conditions but a whole section of officers in the interval suffered and continue to suffer.

(b) My next grievance was in connection with the passing of the Lower Standard Examination and the restrictions that surround the drawing of officiating charge pay of a regiment until that examination is passed. I lost many hundreds of rupees through the action of this rule. This matter is one that always causes the gravest injustice and financial loss to young officers. I am prepared to be questioned at any length on the subject.

(c) Again, somehow or other the rule under which an officer should actually join his appointment before being allowed to draw the pay of that appointment, was broken so as to debar me from drawing the full available allowance of a death-vacancy. The substantive medical officer having died, another officer's name was transferred to the charge of my regiment, he already having a substantive regimental appointment at the time. He was acting Port surgeon at Aden, the regiment with which I was serving was in Manipur (Assam). He was "excused" from joining—therefore, I was only allowed officiating allowance and prevented from being sub. pro tem.—a heavy financial difference to a youngster and utterly unfair.

(d) Further, this regiment was engaged in road making in Assam and all combatant officers received a

special allowance of Rs. 2 per diem. The regiment was in 3 parties, to suit working conditions, each with its separate hospital, 5 or 6 miles away on each side of headquarters camp. I, as medical officer, had to visit all these hospitals but I was not allowed the Rs. 2 daily allowance.

(e) In 1895, I was appointed "Personal Assistant to Principal Medical Officer, Bombay Command," on pay of Rs. 600; up to that time there had been a "Secretary" on the well-known sliding-scale of Rs. 1,000 for a captain, Rs. 1,200 for a major and Rs. 1,400 for a lieutenant-colonel. The work was the same but the designation was contrived to lower the pay.

For over 5½ years I drew Rs. 600 instead of Rs. 1,000.

(f) In 1901, the then Director General, Indian Medical Service, offered me the Medical Storekeepership, Bombay. Here again the same well-known sliding-scale of Rs. 1,200 for major and Rs. 1,400 for lieutenant-colonel was in force, with this striking exception, that the Bombay Depot had always previously been considered too large and important to be held by any officer under the rank of a major, and, therefore, in the regulations, there was no pay laid down for a captain.

I was verbally assured by the Director General, Indian Medical Service, that the pay would be Rs. 1,000 and I possess a letter from his Secretary assuring me to the same effect. After keeping me some months without any pay at all it was announced that my pay would be Rs. 850 and on that pay I had to continue for over 3 years until I became a major, when my pay automatically rose to Rs. 1,200. This incident lost me Rs. 350 per mensem for 3½ years—some 13,000 odd rupees.

(g) Although presidency house allowance has always formed part of the emoluments of the Medical Storekeeper to Government, Bombay; this was taken away from me in November 1916 on my return to that appointment. This means a loss of Rs. 125 per mensem ever since. Other appointments in the Presidency town held by officers who, like myself, are debarred from private practice get a local allowance in lieu, but no house allowance.

I get neither the house allowance nor the local allowance nor the private practice. The next 12 months (until I went on leave) occasioned a loss of Rs. 1,500.

(h) On coming to Madras I find I should have been allowed to draw house allowance here had it not been for the fact that being now a selected lieutenant-colonel, my pay is Rs. 1,500. Those drawing over Rs. 1,400 are debarred from house allowance. Therefore the extra Rs. 100 which I get as a selected lieutenant-colonel has the effect of making me draw less pay

10 March 1919.]

Lieutenant-Colonel F. E. SWINTON.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

than I now would be doing if I were not selected, as I gain Rs. 100 by "selection," but lose Rs. 125.

I observe, in the Regulations governing this matter—para. 286 (a), Volume I—a colonel of the medical staff at the presidency town (whose pay is Rs. 1,800) is allowed house allowance.

(i) I make no special complaint against the loss of exchange compensation allowance; the Indian Medical Service suffer equally with every other service. But this allowance had been in existence so long that it was part of one's pay and it was taken away at a singularly infelicitous time, when expenses generally have increased so enormously.

(j) The net result of all this to me is that the monthly pay cheque from the Controller of Military Supply Accounts is some Rs. 32 or Rs. 34 per mensem more than it was 11 years ago when I was a major in my 15th year of service, in spite of the fact that I receive Rs. 200 per mensem more being now a lieutenant-colonel and Rs. 100 more for being on "selected" list.

The larger income-tax, the larger family pension fund deductions and the loss of house allowance and exchange compensation allowance, bring this about.

The parallel is perfect because I am still in the same appointment, viz., a Medical Storekeeper to Government in a Presidency town.

(k) A rise of net pay from Rs. 1,380 in one's 15th year of service to Rs. 1,414, in one's 27th year is a somewhat striking anomaly. It is not, therefore, very surprising that the Medical Stores Department is not attractive or that I should consider that I have just cause for complaint and discontent.

Q. 3.—Have you met with any instances of friction between the Royal Army Medical Corps and Indian Medical Service?

A.—For some years as a regimental medical officer and as Personal Assistant to the Principal Medical Officer, Bombay Command, I had opportunities of coming across instances of friction between Royal Army Medical Corps and Indian Medical Service.

(a) One common source of friction was over the fair division, between the two services, of appointments to "Cantonment hospitals" and staff surgeoncies. It was laid down that these should be divided equally but it only too frequently happened that with a Royal Army Medical Corps Principal Medical Officer, the equal division took the form of giving the Cantonment hospital to the Royal Army Medical Corps and the staff surgeoncy to the Indian Medical Service. The latter was usually worth Rs. 60 while the former ranged from Rs. 100 to Rs. 150. Some reason was usually found to put forward to justify this course.

(b) Needless to remark it was seldom that an official complaint reached headquarters. In the first place the young Indian Medical Service officer felt diffident about starting a fight with his (Royal Army Medical Corps) superior medical officer, while furthermore, the channel to headquarters led through the office of the Assistant Director of Medical Services (or Principal Medical Officer as it was called then) whose sympathies may be guessed.

Hundreds of Indian Medical Service officers could probably give specific instances with names and dates, of this sort of thing.

On the other hand I have, of course, known Royal Army Medical Corps Principal Medical Officers, who were quite above countenancing any petty unfairness of this nature.

(c) Another source of friction, arising out of the first grievance experienced by the young Indian Medical Service officer on landing in India (I refer to L. S. examination question) came about in this way. It frequently happened, in a big station, that as no recently arrived Indian Medical Service officer had passed his L. S. Hindustani and as he was, therefore, by a most unjust regulation, debarred from drawing the charge-pay of the available Indian regiment, a Royal Army Medical Corps officer would be appointed to the charge as he could draw the pay without passing the L. S. Hindustani.

(d) Beyond the fact that the young Indian Medical Service officer was "doing duty" at the British station hospital, learning nothing either of his future work or of the language, but merely helping to set free Royal Army Medical Corps officers to take charge of Indian regiments there was no particular injustice in the matter. He could not get the allowance, so there was no harm in somebody else drawing it.

(e) But a gross abuse took place on one occasion, to my knowledge, in which, while one of these temporary arrangements was in force, the young Indian Medical Service officer managed to pass his L. S. examination and became thereby immediately entitled to leave the station hospital and to displace the Royal Army Medical Corps officer from the regiment. But the arrangement was allowed to continue and the Principal Medical Officer of the Command, to whose notice the matter was brought, was averse to interfering or ordering the local Principal Medical Officer to put the matter right. The matter came to the notice of the Principal Medical Officer, India (through another channel), and the injustice was righted. But the bad feeling engendered by such episodes lasts a life time. Other (Royal Army Medical Corps) Command Principal Medical Officers, whom I knew would have instantly checked any such unfair practices.

(f) I have never heard of an Indian Medical Service Principal Medical Officer, of either a Command or of a District or Brigade ever giving the Royal Army Medical Corps officers serving under him any similar cause for complaint on the grounds of partizanship.

Q. 4.—Have you any improvements to suggest which would neutralize grievances or friction?

A.—The remedy lies in a nutshell: the Director of Medical Services, India, should be chosen alternately from the Royal Army Medical Corps and from the Indian Medical Service.

Q. 5.—What do you consider as the limit of service that should be fixed for—

- (a) transfer from military to civil employment, and
- (b) transfer from civil to military?

A.—An officer in military employ should be transferred to civil after completing 2 years' service and not later than 5 years.

An officer in civil employ should be transferred to military employ not before his completed 20th year and not after his 23rd year.

But temporary transfers, for 6 months at a time, should take place every 5 years between an officer's 5th year and his 20th year.

Answer to questions on the Medical Stores Department.

(1) The answer to the question will be much more fully replied to by Lieutenant-Colonel Niblock, the Acting Surgeon-General with the Government of Madras. I have supplied him with such information as is in my power to give.

The brief reply is that civil hospitals and dispensaries and local fund dispensaries at present submit their indents, both annual and emergent, on the Medical Store Depot.

(2) The responsibility for indenting rests with the indenting officers. The responsibility for scrutinizing and passing on indents lies with district medical and sanitary officers. The final responsibility for further scrutiny and final countersignature lies with Surgeon-General. It will be seen, therefore, that the Surgeon-General is able to furnish a fuller reply as the matter is one that concerns indents before they reach the Medical Storekeeper.

In my opinion there would be no objection to an arrangement which would ensure the benefits referred to in the question, but I gather that it is the Surgeon-General who should express an opinion.

(3) I fear this question is too vast to be taken up before the Committee at short notice. It has for some time been under discussion and report and I understand that Lieutenant-Colonel Shairp and Lieutenant-

10 March 1919.]

Lieutenant-Colonel F. E. SWINTON.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

Colonel Ross are here to go into the matter with me. The latter has already been furnished with lengthy replies to specific questions put by the Director General, Indian Medical Service.

(a) From the form of this question it appears to be intended to elicit suggestions from one, such as the Surgeon-General, who comes in contact, from outside,

with the working of the Medical Stores Department in so far as it affects the administration of civil hospitals, etc. He probably has general suggestions to offer and has informed me he will submit them.

I shall be happy to answer any general questions which the Committee may desire to put to me after we have been round the depot.

LIEUTENANT-COLONEL F. E. SWINTON, called and examined.

The present establishment of his depot was barely sufficient, though the depot was now better equipped than for some years past. He could never overtake his requirements if Government took years to sanction any new scale recommended. By the time new sanction was received the conditions had generally altered. They were always in a chronic state of "catching-up." The Director General always supported him when he asked for temporary establishment but that, as its name implied was only a makeshift—it took "temporary" men months to learn their job.

There was no reserve for leave or sickness and "special arrangements" had to be made every time a man goes on leave.

Representations regarding an increase in establishment had been made, but in most cases, the sanction came so late that the depot had in the meanwhile expanded still further. The war had of course complicated the whole question.

The establishment was insufficient in numbers. It was among the higher grades that this was most felt. He could always get over a temporary press of work by engaging temporary coolies though such "expedients" were unsatisfactory.

He had asked for better establishment and it had been sanctioned, as a "War measure." There was, however, some difficulty in filling some of the higher technical posts as the men had to be tried and trained before being accepted.

It was only about a month ago that he had up a fresh and final scheme which if sanctioned early and in its entirety, ought to give satisfaction for the next 5 years, if the rate of expansion remained about the same.

He ought to mention that conditions in Madras at present were such that the local government was giving an allowance of Rs. 4 a month to all whose pay is Rs. 9.

In the scheme referred to above he had only recommended Rs. 10 as minimum pay for a "packer" in the depot on the presumption that local allowances would naturally be sanctioned for his men as for others in Madras.

He was not satisfied with the present system of accounting because—

(a) The functions of the Medical Storekeeper and those of the financial authority were too entirely dissociated; a distance of 1,000 miles separated his office from the Controller of Military Supply Accounts' office and they are out of touch. This single circumstance led to all sorts of difficulties.

(b) He did not know for certain what price was being recovered for the goods he issued to charges. The violent fluctuations of prices during war time had not been followed and the price-list compiled and issued by the Controller of Military Supply Accounts was valueless.

(c) *Accidentally* he stumbled across the fact that the Controller had been recovering at the rate of Rs. 2 per gallon for an article of which he had bought some 12,000 and odd gallons at prices ranging round Rs. 4 per gallon. The Controller of Military Supply Accounts' office had seen and passed the bills for these purchases and had issued the cheques in payment and yet the price paid failed to suggest to them that there had better be a readjustment of the costs recovered from institutions.

(d) Thanks to the Controller being so far off he had to keep copies of his ledger (a most laborious task) for his own use while the originals were sent away for audit to Calcutta.

(e) "Objection statements" under the present system were doubly objectionable owing to the writing and delay involved.

(f) A receipt voucher, if subsequently required for inspection, etc., was not available and had to be sent for, as it was more satisfactory to see the original than any copy of "remarks" which his office might have kept.

(g) A large number of petty incidents, arising mostly from misapprehension regarding nomenclature, would not occur if there were facilities for personal intercourse between his office and that of the Controller.

The remedy for almost every complaint brought to notice above, lay in instituting a section of the Controller's office on the Medical Store Depot premises. *He considered the above essential* as most of his troubles were due to the absence of such an arrangement.

All the audit work of a depot, especially a manufacturing depot, must be done on the depot premises. Stock-taking was of two categories:—

(a) Annual.

(b) Running.

(a) Occurred during the month of March and was supposed to occupy the whole-time of the Medical Storekeeper to the exclusion of all other matters.

(b) Went on every day throughout the year and the verification clerk got round the whole depot in the year.

A Medical Store Depot had to be closed for stock-taking because it differed entirely from a business firm.

The information sought to be obtained at stock-taking was the amount of stock actually in the depot on April 1st.

This stock was so vast and so scattered that it was a physical impossibility to count it inside a fortnight and then only *provided* that not less than a fortnight had been previously spent on arranging it for counting.

A knowledge of the exact state of one's stock was essential for two reasons, (a) to check losses and thefts, and (b) to provide a basis for the compilation of the Home indent. In order to know how much to demand factors must be known, namely, "actual stock" and "established proportion."

The "established proportion" was the average quantity arrived at by inspection of past annual actual expenditure over a period of 3 years, for non-perishable and 1½ years for perishable articles.

They indented for the difference between "actual stock" and "established proportion" taking into account any quantities remaining to be supplied on former indents.

It would be seen, therefore, why it was necessary to know the actual stock and why there must be a stock-taking. Another important matter connected with the possession of "actual" figures was that it enabled the Medical Storekeeper *at once* to deal with many of the discrepancies which were to be found in the ledgers, such as wrong posting, cross-entries, writing lbs. for oz., errors due to nomenclature, etc. It was most useful to get on to such errors immediately, and to scrutinize vouchers and ledger, and also recount stock if doubt still remained. To abolish stock-taking would abolish these safeguards.

The reason why the depot must be "closed" for indent or returning work was that it was impossible to take stock if the cupboard, room, etc., which had just been counted and locked up and recorded, had to be opened again a few hours later for stock to be extracted for issue on indent.

It was a mistake to think that the fact that a depot was officially "closed" for one month really meant

10 March 1919.]

Lieutenant-Colonel F. E. SWINTON.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

that everybody urgently requiring medicines could not get them, and urgent telegraphic indents were invariably attended to, regardless of the dislocation of routine.

Again, when discussing this question it should not be forgotten that to each of the eleven other months of the year, a group of hospitals was allotted as the month for submitting their annual indents.

It was carefully arranged beforehand, at all depôts, that no annual indents at all are due in the month of March. Everybody concerned knew this and acted accordingly, and had, or should have, all his requirements beforehand.

It was only, therefore, "extra indents" which found the doors of the depot closed and these were usually submitted by officers who have wrongly estimated their requirements for the year. In a few cases, of course, genuine unforeseen needs arose and such were always attended to. His depot issued a warning slip to all concerned, civil and military, one clear month before stock-taking, warning every body to think of and obtain any little requirements before February 28th. It could, therefore, be very seldom that there is any genuine need for submitting an indent on the depot during March.

On the other hand, business firms are under no necessity to make out their Home indents according to an "established proportion." They are, therefore, not under the same necessity of knowing their actual "stocks." Furthermore, they were enabled by the artifice of holding a widely-advertised "stock-taking sale" to get rid of the bulk of their stocks so that not much was left to count. Business firms were not tied down to one Home indent a year; they were in the habit of ordering something by every outgoing mail and of receiving goods by every incoming mail steamer throughout the year. This put them on a very different footing from a Medical Store Depot.

The depot equipment list is not up-to-date and is not sufficient for the requirements of civil and military hospitals. If revised, say, once a year, it would certainly meet all reasonable requirements. Of necessity, it must always be in state of "catching-up" with advancing knowledge.

Medical Store Depôts did not compete with the ordinary chemist and druggist of the town; they issued nothing to the general public. Undoubtedly their prices were lower (apart from the fact that the quality was better) because they did not go in for making excess profits. He knew of one instance where an officer, after obtaining some thymol at a chemist's shop, found that he had paid for it four times the price charged by the Medical Store Depot.

Had it not been for the Medical Stores Department with its huge stocks of good drugs, for all needs of civil and military hospitals, at the commencement of this war, coupled with the fact that there were also laboratories which enabled them to turn out large quantities of essential drugs and supplies including instruments, Government medical institutions would, during the past four years, have been at the mercy of profiteers.

In reply to a question as to why there are several different prices for the same article, he stated that the Medical Storekeeper had nothing to do with pricing. There were three classes of institutions with three different degrees of claims upon the Medical Stores Department. First, the military department, which because the whole cost of the Medical Stores Department was borne by the military estimates, received their requirements, without any charge. But a list of "military" prices was maintained to meet such cases as the calculation of "loss statements" or "recoveries for breakages," etc. These prices are actual cost prices. In the second degree stand the purely Government civil hospitals and dispensaries and charitable dispensaries both medical and veterinary. These are charged at somewhat higher rates to make up for the fact that the charges on account of losses, breakages, deterioration of stock, and interest on capital outlay involved in maintaining large stocks are not shared by the civil department. In the third category were the municipal hospitals and dispensaries and private bodies which, not

being purely Government institutions, are charged a slightly higher rate. The Government of India are responsible for the rules governing pricing.

He thought that Government should be engaged in larger manufacturing activities, only up to the limit set by Government's own requirements, as is done at present.

Indian raw products should be used as much as possible wherever they were as cheap and as good as the imported article, but not otherwise.

Government must always keep in view, and be prepared, both by provision of machinery and staff, to meet sudden calls for expansion, such, for instance, as a war, epidemic, etc.

He considered that Government should attempt to pioneer new drug industries in India, in the future as in the past. By this he meant that it should continue to take every opportunity of making, in the laboratories of its own Medical Store Depôts, everything that it was possible to make by utilizing the resources of India, Ceylon and Mesopotamia to the utmost. But there was no need to attempt preparations outside of or in excess of Government's own requirements, merely for the sake of "pioneering an industry" which would subsequently be handed over to others. He had learnt by experience that, in the absence of a "Food and Drugs Act," few firms in India were fit to be trusted in the matter of drug manufactures. The Medical Stores Department was, without the added stimulus of legal penalties for wrong doing, to be trusted to issue nothing but the best and it continually called in the aid of the Chemical Analyser to Government to secure this end.

Government, in the Medical Stores Department, had for many years been turning out medical stores as well and as cheaply as manufacturing firms in England and abroad, not only drugs, but surgical instruments and dressings. The number of drugs manufactured at the depôts at Bombay and Madras had greatly increased during the past 4½ years. This ability on the part of the depôts to render India partly independent of Home during such a period of stress had been invaluable.

As for the surgical instruments (made by the Bombay Depot) he could speak from his own knowledge to the fact that the quality was of the highest possible standard and the price very low.

The Medical Storekeeper has no objection to additional indents and to "urgent" indents for small quantities. Unfortunately, far too many of these "extra" indents are not truly and really "urgent." "Urgent" indents took precedence before the other routine indent work, which they dislocate, and it was only when they became too numerous and when the Medical Storekeeper had reasons to believe that the alleged "urgency" was fictitious that he felt that the work of the depot was being unfairly disturbed.

The Medical Storekeeper had no power of scrutiny (except when scale quantities were concerned) nor could he possibly be expected to exercise such powers, as he dealt with some thousands of indents per annum. It was the duty of others to scrutinize indents and in many cases a few minutes per week would suffice for all the indents, annual and supplementary, that passed through the office of any given administrative officer. Many officers evaded the regulations by which the sanction and scrutiny of an administrative officer was ordered and sent their indents direct, thus escaping scrutiny on the plea of "urgency."

It was always difficult for a Medical Storekeeper to contest an indent; such action was often regarded as "obstruction" or "hampering the medical officer in the treatment of the sick" and so forth. Every hospital was entitled to its annual indent and to a reasonable number of extra or "urgent" indents; it was the abuse of the privilege that gave rise to objections from the depot point of view.

He objected to indents which came from municipal presidents and others, without being checked by a medical officer, for several reasons (a) he objected to issuing drugs which are poisonous to irresponsible laymen, (b) no laymen had any right to deal with a medical

10 March 1919.]

Lieutenant-Colonel F. E. SWINTON.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

stores depot unless their demands were scrutinized by a medical officer, (c) considering that each chairman or president was in touch with his own medical officer, he could not see why the latter should not be detailed to sign and submit the indent. The chairman would, of course, countersign the indent and pass it on to the civil surgeon (in Madras the "District medical and sanitary officer") who would transmit it to the Medical Storekeeper, (d) one of the causes of trouble and delay in compliance with indents was the strikingly unintelligent way in which some indents were filled in, (e) there was a certain official nomenclature the use of which facilitates the work of all parties, Controller of Military Supply Accounts included. There would be more chance of that nomenclature being used if the municipal medical officer filled in an indent.

He considered that improvements might be made in the method of indenting for medical stores from Europe as follows :—

(a) The interval which elapses between framing the indent and the arrival of the stores in India was unnecessarily great and might be shortened by co-operation between the Director General of Stores and the Director General, Indian Medical Service.

(b) There were a very great number of items, repeated in successive indents year after year without any alteration, whatever, except that the quantities fluctuate. He thought that the Director General of Stores might hasten supplies and lighten his own task of dealing all in one block with such a huge indent, if he were to act in advance, before the actual consolidated Home indent reached his hands, by entering into contracts for the supply on, say, April 1st, of 75 per cent. of the quantity of certain items demanded in the previous year's indent.

It is known, for instance, with tolerable certainty, that such items as Chloroform, Acid-Acetyl, Salicylic, Iodine, Iodoform, Sulphur, Bromides, Iodides and many sundries and appliances are required in large quantities every year. The exact list would be a matter for the Director General to settle and the names only (or better still the item nos. in the last indent) could be sent Home for the suggested preliminary 75 per cent. contracts. Such chosen items would begin reaching this country in the very beginning of the financial year to which they pertained instead of about July or August.

(d) He thought it was also quite possible to divide the mass of work now all concentrated into one hurried and crowded time of year by dividing the Home indent into its component sections and spreading the work over a longer period. Each section, drugs, chemicals, sundries and surgical instruments and appliances could be finished off separately at successive short intervals with less haste and more careful scrutiny.

(e) He did not suppose the Director General of Stores would object as he did not employ, for instance, the same contractors for drugs as for instruments. The giving of one contract to, say Evans Lescher and Webb had no reference to, and need not be synchronous with, the giving of another contract to, say, Arnold or Down Brothers.

(f) The weeks in which the Home indent was being prepared and priced and scrutinized in its entirety were more or less monopolized, to the detriment of routine work.

The matter was worth consideration by a Committee of Medical Storekeepers as valid objections might be brought forward. He had little or no complaint to make against the Stores Department of the India Office. Medical Store Depots had been well served for years past, and any idea that we should do better for ourselves by dealing with tradesmen in this country, instead of with the India Office, would prove a great mistake.

The method of pricing.—He presumed that by this, was meant that operation as carried out in the office of the Medical Storekeepers at the time of the submission

of the Home indent to the Director General, Indian Medical Service.

It was a difficult and laborious task performed with the aid of deficient data, sometimes in error, thanks to market fluctuations since the last invoice prices were received.

In war time pricing had often proved to be guess-work and very inaccurate. In many cases there were no Home invoices to refer to, none of a particular item having been supplied from Home because it was not available. Local price lists afforded certain help but very little.

He suggested that if the Director General of Stores would send out half a dozen copies of latest prices current in London about a month before the pricing had to be done in India, all gross errors would be avoided as in peace time the fluctuations would not be so violent as to vitiate the quotations set down.

Method of accounting.—The stores as received into the depot were brought to account on the depot books in the usual way but it often happened that owing to the enormous quantities of, for instance, bottles, received in batches at any one time, they had to be taken on stores at "face value" and breakage ascertained and written off later.

Also, when stores were received in the month of March, they had to let them lie for a month.

During the recent war the Home Invoices had sometimes been received at the depot very late.

He was strongly opposed to the suggestion that there should be any further separation between the purely "stores" such as functions and the manufacturing functions of the Department. At the present moment the accounts of the "Depôt" and "Laboratory" were separate and the stock of raw materials for use in the Laboratory was kept as close to the Laboratory as possible, but that was a totally different thing for geographical separation. At two places at least (Bombay and Madras) the Medical Stores Depot should combine the two functions.

If one were to separate the "Stores" from the Laboratory it would be the splitting up of an already small Department into two still smaller ones, which would injure its value as a training ground. It would add greatly to supervision charges. The "Stores" atmosphere was good for those for the time being in the Laboratory, and the "manufacturing" atmosphere was good for those doing, at the moment, purely "Stores" work. Neither function was entirely strange to anybody from the Medical Storekeeper to the packers, and men were interchangeable at short notice.

He did not consider that the Government Medical Stores Department was run on business lines. It never would be run strictly on business lines because so many of its functions were unknown in commercial life, such as all that portion of the work connected with vouchering, and all the issue work, checking of indents, etc. The tradesman was not interested in seeing that his customers did not waste their money. The best tradesman contented himself with giving good value for money but his dealings were only limited by the estimated solvency of his customers. The tradesman did not take back into stock and give credit for "part worn" goods and articles "no longer required." The business man who submitted himself to the depot system of accounts would soon find himself bankrupt. He did not think it necessary to employ a business man in each Medical Store Depot, but considered that every Medical Storekeeper should go through a course of "Economics."

He was opposed to any change being made in the names of the Medical Store Department, or in the designations of its officers.

He was in favour of employing a highly qualified chemist at every Medical Store Depot.

11 March 1919.]

Lieutenant-Colonel A. MILLER.

*(The schemes and questions referred to by witnesses are contained in Volume III.)***At Madras, Tuesday, 11th March 1919.**

PRESENT :

S. R. HIGNELL, Esq., C.I.E., I.C.S. (*Presiding*).

MAJOR-GENERAL G. CREE, C.B., C.M.G., A.M.S.

MAJOR-GENERAL P. HEHIR, C.B., C.M.G., C.I.E.,
I.M.S.

MAJOR-GENERAL H. HENDLEY, K.H.S., I.M.S.

THE HON'BLE MAJOR-GENERAL G. G. GIFFARD,
C.S.I., I.M.S.MAJOR M. T. CRAMER-ROBERTS, D.S.O., Indian
Army.

and, as co-opted members SIR T. NARIMAN, Kt., and LIEUTENANT-COLONEL BHOLA NAUTH, C.I.E., I.M.S.

MAJOR A. A. McNEIGHT, I.M.S. (*Secretary*).

LIEUTENANT-COLONEL A. MILLER, M.B., I.M.S., Principal, Medical College, Madras.

*Written statement.**Scheme B.*

The following indicate the modifications I think necessary in this scheme :—

5. Seconding from the Royal Army Medical Corps should be a temporary measure only.

6. Seconding from the Royal Army Medical Corps as stated above should be a temporary measure. The permanent transfer of the required number of Royal Army Medical Corps officers should be encouraged. After that the new unified service should be entirely recruited by competitive examination. Permanently transferred Royal Army Medical Corps officers should be graded in the unified service according to service and not rank—otherwise unfair to Indian Medical Service officers now in service.

But if it is decided to continue seconding Royal Army Medical Corps officers the entrance examination for both the Royal Army Medical Corps and the new Indian Medical Service must be identical, and seconded officers, when serving in India, must be graded according to the positions they obtained in the competitive examination. If this is not done I foresee a just cause for complaint and friction is sure to continue.

7. If seconding of Royal Army Medical Corps officers is purely a temporary measure, and the medical services in India become really unified—that is, one service only—the points raised in this paragraph will disappear. Seconded officers of the Royal Army Medical Corps should not be eligible for civil.

8. The Director, Medical Services, should always be an officer of the unified service. The suggestion that the Director should sometimes be an officer of the Royal Army Medical Corps from Home who may have had little or no experience in India shows that there are no great hopes of really improving the service. The analogy regarding the Commander-in-Chief will not apply to a properly unified service, because the officers in that service will be attending British and Indian troops throughout their service, whereas the Commander-in-Chief will be commanding troops from Home as well as Indian troops. If British troops joined the Indian army for their whole service as Indian medical officers do, it would not be fair, provided a man of sufficient ability is available in India to appoint an officer from Home to be Commander-in-Chief.

10. Provision should be made for giving facilities for learning the Indian languages, and if, owing to the exigencies of the service, such facilities are unavoidably wanting, medical officers should not be penalised. As in the Staff Corps, medical officers should be allowed a certain time in which to pass their language examination, and their pay should not be less until they have

failed to qualify in the allotted time—subject to facilities being available.

12. The anomaly referred to applies to *present* conditions. If the suggestions made in the last part of paragraph 17, regarding frequent interchange between the military and civil sides is properly carried out, this anomaly will cease.

13. Residuary appointments should be defined by the Government of India in consultation with the local government. I would suggest the following as applicable to this Presidency :—Surgeon-General, Inspector-General of Prisons, Sanitary Commissioner, Director, King Institute, Guindy, and the Professors of medicine, surgery, midwifery, ophthalmology, pathology and chemistry.

14. The proposals in this paragraph constitute, I consider, the worst part of this scheme if a contented service is one of the aims. The Director General should be the head of the whole unified service, should be Secretary to the Government of India and should never hold rank below that of lieutenant-general. Under him should be two Deputy Director Generals, one for military, the other for civil, ranking as major-generals. Surgeons-General of provinces and Inspectors-General of civil hospitals should rank as at present.

15. I consider the minimum of five years before an officer can be seconded to civil too much. Three years would be better.

With regard to the next proposal in this paragraph, the “indispensable residuum” must be defined, but the proposal to make an officer ineligible for any civil post if he reaches 20 years’ service without obtaining a residuary appointment appears to me either to anticipate a very large “residuum” which would do away with a considerable part of the military reserve, or to suggest that most civil posts will be kept for juniors—which would be very unfair and prejudicial to the service. I, therefore, think the proposal unworkable; it would cause great dissatisfaction.

16. The words “English-registrable” should be deleted. No distinction should be made between the qualifications required for civil medical practitioners and civil assistant surgeons.

17. Any Advisory Board such as those suggested in this paragraph and serving under the Government of India should be so constituted as to represent all the provinces: nominations to the Boards should, therefore, be made by local governments. It would be unfair for members of the Board to be drawn from one part of India.

Under this scheme no officer except those holding residuary appointments will be exempt from military

11 March 1919.]

Lieutenant-Colonel A. MILLER.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

duty, and the remarks above regarding paragraph 13 apply to the latter part of this paragraph.

18. If alterations in leave rules are necessary, careful consideration should be shown to those officers who have been obliged to accumulate leave through no fault of their own. For instance, for senior officers, six months' leave on full pay is not equivalent to twelve months' combined privilege leave and furlough and if the period of leave has to be curtailed, then the length of service required before leave can again be taken should also be correspondingly curtailed.

20. This requires very careful consideration. The proposal is objectionable so far as civil posts are concerned, because language, habits and customs vary so greatly in different parts of India, and if officers are transferred from remote parts, they, as well as their work, will be at a great disadvantage. I consider, therefore, that civil officers should, *as a rule*, be permanently allotted to presidencies.

24. I consider there is nothing in this scheme which can be calculated to make the purely military part of the service more efficient except perhaps the proposed frequent transfers between the military and civil sides, but as, from paragraphs 12 and 17 (latter part) the author of this scheme evidently considers frequent transfers from civil to military will not make an officer much, if any more, efficient for military service, I presume the same would apply to transfers from military to civil. If so, there is nothing in this scheme to promote efficiency in the military side. I consider the only way in which the professional efficiency of the military service can be maintained is by associating, as far as possible, every military medical officer with civil medical practice and that the aim should be a real unification of all the medical services in India.

Conclusion.

I think this scheme has many good points and some bad ones. It does not go into details as scheme C does but I prefer B to all the other schemes, as with modifications, and with details filled in, it could be made into a scheme which would result in an efficient, progressive and contented service.

Scheme C.

The following are my remarks regarding the scheme under the various heads :—

I do not agree that a long period is required to bring about the unification of the medical services in India. If sufficient inducements regarding nature of service, pay, leave and prospects are offered, I believe, the unification could be rapidly accomplished.

2. The military side should not be separate in name or fact from the civil side. Both should belong to one unified Indian Medical Corps.

A.—Indian Military Medical Service.

5. The immediate head of the military side should be a Deputy Director General working under the Director General of the whole service.

6. (ii) *Vide* remarks on paragraphs 5 and 6, scheme B.

(iv) Only *very* few have qualifications which would enable this to be done.

10. *Vide* remarks under 5 above. I strongly object to Army Medical Service officers being appointed. The head of the military medical side should be an officer well acquainted with conditions in India, and should be selected from the unified service.

11. All administrative officers should be selected from the unified service.

15. One service is required. The Secretary of State for India agrees with this.

17. Royal Army Medical Corps officers should be invited to transfer permanently to the unified service. Seconding of Royal Army Medical Corps officers should cease as soon as the unified service is properly constituted. But if it is decided to continue seconding, pre-

cautions are necessary (*vide* remarks under paragraph 6, scheme B).

The last sentence of this paragraph is very objectionable and should be deleted. To my knowledge failed candidates for the L.M. & S. go to Edinburgh and take the L.R.C.P. & S. easily—often in six months—and I cannot remember hearing of a failure. The M.B., B.S., Madras, is very much better than many qualifications at Home, but I agree that some training in the United Kingdom is required.

18. I must again object to seconding Royal Army Medical Corps as a permanent measure.

22. If civil medical officers, except those holding residuary appointments, are transferred to military duty as suggested in the next paragraph, they will remain fit for military duty and this provision is unnecessary.

23. This provision will not be of much use if paragraph 22 is insisted on and it will hardly be worth while disturbing the civil side if so little is thought of the efficiency of this measure.

Three months every five years should be sufficient—six months should be the maximum.

24. If 23 is adopted, a two months' course should be sufficient. Officers should not lose pay during the course.

25. This will render the service most unpopular, and will not increase the efficiency of the service as a whole. It will be practically impossible to carry out these examinations in the case of officers seconded to civil as their work would be seriously interfered with. It would be very objectionable to be compelled to get up military subjects whilst in civil and officers in military would have an unfair advantage in such subjects. These examinations are unnecessary if provision is made to keep officers efficient by regular professional work amongst military and civil patients and if the provision suggested in paragraph 23 is properly carried out.

26. *Vide* remarks on paragraph 17, scheme B.

27. Military assistant surgeons should not be recruited as at present, but by open competition (open to all classes—Indians and Anglo-Indians—as for civil assistant surgeons at present) *after* obtaining their medical qualification. If it is thought necessary to continue recruiting any of the present class of Anglo-Indians as military assistant surgeons it is absolutely necessary for Government to establish a college for the preliminary education.

28. I look upon the sub-assistant surgeons as an anomaly—although a necessary and a useful one at present. Their education is being steadily improved and the aim should be to continue the improvement until they can take the full medical course and obtain proper medical qualifications.

30. The words 'have not reached the rank of lieutenant-colonel and' should be deleted. Officers of that rank would be most useful for medical and surgical appointments especially in base hospitals. Only residuary appointments should be exempted from the war reserve.

I think an annual military training for civil practitioners who join the war reserve too frequent. It would interfere with their practice too often. Better a longer training at less frequent intervals.

37. X-Ray electro-therapeutic experts should be included in the list.

38. *After* the words "United Kingdom" add "and India." I prefer the proposal in paragraph (j), scheme A.

B.—The civil medical services of India.

43. (i) The head of the civil side should be the Deputy Director General serving under the Director General. The head of the civil should be selected from those officers who have been in permanent civil employment and not from the whole Corps.

(ii) The Surgeon-General of a province should *usually* be selected from the civil medical officers in the presidency concerned, as he would know the province and the men. A stranger would be much less efficient.

(iii) For the same reasons an Inspector-General should be selected from the local civil staff whenever possible.

11 March 1919.]

Lieutenant-Colonel A. MILLER.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

(iv) (a), (b), (c) and (d). These are all objectionable. Civil executive medical officers should consist entirely of officers seconded from the unified service.

44. If this means doing away with first and second class civil surgeons or districts, I agree. But a graded salary should not apply to special appointments such as professorships, bacteriological departments, etc., and the salary of those officers who are debarred from private practice should receive special consideration.

45. Medical officers should serve on the military side for at least three years. The normal term of probation for officers in civil should be three years. I do not understand the last sentence.

46. I object to this. *Vide* my remarks on paragraph 20, scheme B.

47. *Vide* remarks on paragraph 17, scheme B.

49. The same principle should apply as in paragraph 44.

50. I agree, especially with the latter part of the paragraph.

52. I think sub-assistant surgeons require a study period of 12 months. If they are so good as to only require six months, they should be graded above assistant surgeons.

Answers to questions for witnesses.

1. (a) Neither the Royal Army Medical Corps nor the Indian Medical Service (military) afford sufficient facilities for the maintenance of professional efficiency and generally speaking, the more senior an officer becomes, the less efficient he becomes professionally. The reverse generally obtains in civil medical practice.

(b) The extreme difficulty so frequently experienced by Indian Medical Service officers in obtaining leave has necessarily injuriously affected their mental and physical capacity, and has prevented many from keeping in touch with the latest developments in medical science.

(c) The existence of the two military services in India with the Director, Medical Services, always drawn from the Royal Army Medical Corps together with the marked preference shown by administrative officers for those of their own service has produced considerable friction and discontent and these will continue so long as these causes continue.

None of the schemes will be of any real use in promoting and maintaining professional efficiency on the military side. The proposed college can only have a transitory effect on individual officers and I regard the attempt to maintain efficiency by means of periodical examinations as futile. All such expedients are useless if facilitates for real and continuous professional work are wanting. I believe the only remedy is to, as far as possible, combine civil and military medical work and no military medical officer should be entirely employed on military work for any long period until he attains administrative rank.

Schemes B and C have good points but I do not think either of them will produce an efficient and contented service, or attract the class of men desired unless they are considerably modified, and my reasons for the view I take are shown in the remarks made on those schemes, herewith enclosed.

2. It is impossible for me to express any opinion as to what sort of scheme would meet with the approval of the War Office. I think such approval largely depends upon the influences brought to bear upon that office. But if the modifications I have suggested can be adopted, I believe either B or C scheme will fully meet the needs of the army in India.

3. I do not consider that any one of the schemes submitted will attract a good stamp of recruit or meet the demands of professional opinion in England and in India, but if modified as suggested, I believe either scheme B or C would do so. The respects in which I consider these two schemes fail and their remedies are shown in my remarks upon the two schemes.

4. I can only speak of Madras. A considerable number of civil officers and their wives and children have found it necessary to come to the Presidency town to

obtain European medical attendance. I know nothing about military officers and jails.

5. I consider B or C as modified will meet the needs of the civil administration in India. A civil medical service kept as a war reserve must always be affected by a large war, and I do not think that any reserve which could be kept in India at the present time or in the near future could possibly fully supply the needs of a war such as that just ended, but, provided the cadre of the proposed medical service is not kept at its lowest possible limit—which has been the case with the Indian Medical Service for some years past—the civil medical work should not be unduly upset by the withdrawal of the war reserve and moreover the number of qualified medical men in India is increasing every year.

6. Yes, provided all the medical services in India are really unified and all officers, assistant surgeons and sub-assistant surgeons enter the service with a liability to serve in military if required. In this connection see latter part of paragraph 16, scheme B. This portion of the scheme with details fully worked out, would, I consider, form a considerable addition to the war reserve.

7. Yes.

8. The Indian Medical Service reserve (civil side) has proved of great value both directly and indirectly—directly in supplying the immediate needs in the early part of the war and indirectly in supplying the hundreds of temporary Indian Medical Service officers, trained by them in the medical colleges in India.

9. Recruitment for the new service, as soon as the transitional stage is passed, should be solely by open competition in England and perhaps to a certain extent in India. But if those with Indian qualifications are permitted to enter through a competitive examination held in India, all officers thus recruited should immediately on entering the service, proceed to England for a period of not less than 12 months actually in England. For such officers the atmosphere of the great medical schools in England as well as social training is very necessary. Their time should not be taken up in preparing for English qualifications—those Indian qualifications recognized by the General Medical Council are quite good and some of them are better than some of the Home qualifications—but I would suggest that the first six months would be profitably spent in holding house appointments in large hospitals and the second six months at the Millbank Military College. None of the schemes, therefore, satisfy me with regard to the method of recruitment.

10. The special leave for study must be regarded as study duty and not leave. It should not be combined with leave and the regulations should require that the period so taken is really employed for study. Study duty should be compulsory and should be generally limited to 12 months, which may be divided into two periods—the first—the longer one—before the 10th year of service; the remainder—generally shorter—between the 10th and 20th year of service. But special departments may require special considerations, e.g., for the chemical department the Government of India desire officers to take the F. I. C. and the courses prescribed by the Institute of Chemistry made it necessary for me to attend King's College for two years.

11. Yes, a special department of research is required and each Presidency town should have its special hospital and school.

12. The private practice of Indian Medical Service officers has considerably declined owing to the large number of practitioners, continually increasing, who have been trained in India. These include private practitioners and medical subordinates of all grades.

Answers to questions to be asked of service officers.

1. Five years in military. Seventeen years in civil.

2. My causes for complaint are two—one general and the other personal. The first is the difficulty and anxiety connected with obtaining leave. On two occasions I did not know I could go till the last moment and

11 March 1919.]

Lieutenant-Colonel A. MILLER.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

received permission by wire. Such a condition prevents an officer from making arrangements regarding his personal effects and generally means loss. I am aware the difficulty in obtaining leave has been partly due to the exigencies of the service, but it has also been largely due to keeping the cadre of the Indian Medical Service far too low and partly to failure to provide the required extra number of officers when 'study leave' was introduced. Most of the Indian Medical Service officers have, therefore, been unable to obtain the leave earned by them and have large accumulations of leave.

The second refers to the chemical department and the unwillingness of Government to give any consideration to exceptional cases, however small the number of officers concerned may be. In my case, after working for two years for the F. I. C. and using up nearly all the leave I have had for that purpose I found myself in an appointment without private practice and drawing less pay than officers who had done little or nothing extra and were also allowed private practice. I represented my case but only received the usual stereotyped reply that 'Government saw no reason, etc.' It is now too late to do anything in my own case, but if qualified men are to be obtained in the future for this department, their pay must not be left to luck as it is now.

3. Not personally but I have heard of cases. The difference between the two services consists of something more than friction as will be seen by the following statement received from a senior Indian Medical Service officer lately returned from active service: 'There were nine Royal Army Medical Corps regular officers and 13 Indian Medical Service officers when I was there. All the Royal Army Medical Corps officers were given the temporary rank of lieutenant-colonel, several of them having only 4-8 years' service—only four Indian Medical Service officers received similar temporary promotions.' It is impossible to expect a service to sit down under such conditions.

4. I consider the only way in which grievances and friction can be eliminated is to have one service—and absolutely one only—in India.

5. (a) The limit should be ten years.

(b) There is no necessity for a limit if the proposed transfers between military and civil are carried out.

N.B.—Q. 2.—Another general cause of complaint is the insufficient allowance granted to civil Indian Medical Service officers when transferred, and the serious financial loss thereby frequently occasioned. Indian Medical Service officers in military are, I understand, much more liberally treated when transferred.

Answers to questions to be asked of officers regarding assistant surgeons and sub-assistant surgeons.

5. Yes—up to 15 years' service.

6. Civil medical subordinates should be directly under the orders of the Surgeon-General and chief medical officer of the district or station as the case may be. They should not be appointed to posts by district boards or municipal councils. At present they have too many masters, and so long as the Surgeon-General is unable to make the appointments, it will be impossible to ensure that medical subordinates are given suitable appointments or to properly organize the medical services.

7. I think the sub-assistant surgeon must be used as at present—that is, he takes the same position with the Indian troops that military assistant surgeons take with European troops until his status can be improved. This is gradually being done and eventually only assistant surgeons should be used, having the same medical qualifications as those now obtained by civil assistant surgeons.

10. Yes. I think there is, especially if there is a real unification of the medical services in India. The sub-assistant surgeon, as noted in paragraph 7, should gradually disappear.

11. Civil assistant surgeons and civil sub-assistant surgeons should be liable for military duty up to 15 years' service.

13. Nearly all were transferred to military—only a few occupying what may be called residuary appointments being retained.

14. They may be used in smaller civil appointments as at present, but any marked increase in these appointments would probably cause injustice to civil assistant surgeons and great dissatisfaction. It would be better, if possible, to allow most of this class to work out their time in military—sub-charges might be found for them.

15. My reply to this question depends upon whether it is considered desirable to retain military assistant surgeons in their present subordinate position. If it is considered desirable to retain them in their present position, my reply is that their present system of education should be continued with the proviso that their present standard of preliminary education must be improved. It would also be convenient if a central medical college could be established to specially train this class, so as to make room in the medical colleges where they are now trained for more University students, an increase of this latter class being urgently required.

It is decided that military assistant surgeons should not be retained in their present subordinate positions, no further recruitment should take place.

16. My answer to this is an undoubted no for the following reasons:—

(a) The vast majority of this class are totally unfitted for such an education, and would never pass the necessary preliminary educational test. I, therefore, regard the proposal as an impossible one.

(b) If it were possible, they would then be placed, as regards professional qualifications, on an equality with their Royal Army Medical Corps or Indian Medical Corps officers; most of them would undoubtedly resign the service at the first possible occasion, and the service would automatically cease.

(c) These boys are educated absolutely free of cost—including books, apparatus, bedding and subsistence allowance. The position they obtain in the Indian Medical Department is a better one than many of their class get to in other departments or walks of life, and is I think, as much as they have a right to expect. I do not think that an expensive education, at public cost, which will leave them free to please themselves after a few years' service to the State can be justified as a general measure.

But now and then we get a thoroughly good man that really deserves pushing on. I should like to see a few scholarships—real scholarships for ability and not stipends for indigent students offered to such, so as to enable them to obtain full medical qualifications and as a stimulus to Anglo-Indian education generally.

17. If so educated, I think he would undoubtedly expect to receive a commission after a few years' service, if not earlier, and if that were not granted I think he would speedily decide his employment for himself as indicated in my answer 16 (b) above. Many of these men, if so educated, would easily obtain work and eventually practice at Home.

Answers to special questions.

1. The preference shown by Europeans in India for European medical attendance is based on several factors:—

(a) Racial predilection is undoubtedly one, and especially so when ladies are concerned.

(b) It is my experience and that of most of the teachers in medicine with whom I have come in contact that Indians are much better at theory than at practice, so that although many Indians are capable of taking good qualifications, in the practice of medicine the European is generally much the better man. This is largely because, Indians generally exhibit very little real interest in their profession but look upon it purely as a means of making money, which they are prepared to do in the easiest possible manner. The reason for this is shown under (c).

(c) The classes from which Indian medical students are drawn are generally of a very much lower social

11 March 1919.]

Lieutenant-Colonel A. MILLER.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

standing than those from which European medical students come. Generally well-to-do Indians trouble very little about educating their sons with the object that they should obtain their livelihood. The result is that the college students including professional colleges are generally drawn from the indigent classes, and this is made possible owing to the fact that higher education in India is practically free, college students only paying a very small moiety of their educational expenses and often none at all. The Indian medical man is, therefore, generally of a much lower social standing than European medical men, and their manners, standard of living, dress and cleanliness even, are often not such as would allow Europeans to adopt them as their family

doctors.' But occasionally we do get men of the right stamp and these generally make good, and are thoroughly appreciated by both Europeans and Indians.

2. *Vide* answer to question for Witnesses no. 4.

3. The professional efficiency of Indian medical officers (military side) undoubtedly tends to deteriorate with seniority. There is, however, not the slightest doubt that the efficiency of all Indian Medical Service officers, compared with that of 10—20 years ago, has enormously improved, owing to the advances made in medical science, the opportunities afforded by study leave to keep up with those advances, and the very much better equipment now supplied to Government hospitals and medical colleges.

LIEUTENANT-COLONEL A. MILLER, called and examined.

(General Cree.) In suggesting in his written statement, that seconded officers of the Royal Army Medical Corps should not be eligible for civil employment, his intention was to attract officers of the Royal Army Medical Corps to the unified corps. The idea was that as many as possible should be encouraged to transfer permanently. Transferred officers together with Indian Medical Service officers would all form one corps. He understood the scheme contemplated that temporary seconding would go on as a permanent measure. It would greatly reduce the efficiency of the civil side if officers were to go to civil for five or six years only and then revert to military. The underlying idea was that there ought not to be any seconded officers at all except as a purely temporary measure when the unified corps is being formed.

(General Hehir.) As stated in paragraph 6 of his written statement, importance should be attached in the new unified corps to the length of service of a Royal Army Medical Corps officer rather than to his rank. The question of the promotion of Indian Medical Service officers as compared with that of the Royal Army Medical Corps had been a serious cause of discontent. Under the present conditions the Royal Army Medical Corps officers were better looked after than the Indian Medical Service.

To do away with the objection which had been raised that the military training of the Indian Medical Service officer was not adequate it would be well to send the Indian Medical Service officers for military training for a period of three months or a maximum of six months every five years.

Surgeons-General of Presidencies and Inspectors-General of Civil Hospitals should rank as at present. The rank of Surgeon-General in the civil should be given in the same way as in the military. It would not matter much whether they got the actual grade or rank so long as the position was the same.

The minimum of five years before which an officer could not be seconded to civil was too much. He recognised that this would depend on the number of vacancies in the civil, and that a large number could not get into civil before five years. He could not suggest any means of shortening the waiting period. If the cadre of the Indian Medical Service were much bigger the waiting period would be longer. Of course the increase in civil appointments would not correspond with the increase in the cadre of the corps. He admitted that this might lengthen the waiting period. He was aware that about half of the appointments on the civil side did not really belong to the war reserve.

He had not gone into the details of the constitution of an Advisory Board. One of the chief necessities was that it should consist of representatives of all the provinces. It would produce a great amount of dissatisfaction if the members were drawn from a particular place, say Delhi or Simla. His intention was to guard the interests of those who were far off from headquarters.

The seconding of officers from a purely military service for employment in civil would not conduce to the improvement of the latter.

He did not approve of the examinations, proposed in scheme C, for promotion from captain to major, and

from major to lieutenant-colonel, unless there were some military consideration that rendered them necessary. It was wrong to promote an officer if he was not professionally fit for promotion. These examinations would take the place of professional work, and all who attached importance to professional work disapproved of them.

Military assistant surgeons were primarily recruited for duty in British station hospitals, and the introduction of Indians might complicate matters. He would not go so far as to say that recruiting for military assistant surgeons under the present circumstances should be stopped. It was for the military authorities to say whether they desired to retain them in their present position, or, if not, whether they wanted the present system to continue with certain modifications. Anglo-Indians had no right to expect absolutely free education by which they could qualify themselves to be placed in a position of rivalry with Royal Army Medical Corps officers. To remove the present discontent it would be well if their course was extended to 5 years, and they were given qualifications registrable in India, and made medical officers or house physicians, though still remaining in a subordinate position. Their preliminary qualifications should be improved. A central government college should be opened for the purpose, and from it candidates should be selected for the Medical College. A large number of the boys now being trained as military assistant surgeons were not suitable, but if a central college such as suggested by him were established, the head of the college would be able to send suitable candidates. A great training college was required for Anglo-Indians, but if it was to be a purely medical college there would be a great deal of waste, as many Anglo-Indians joining the class proved failures.

He was opposed to the proposal to get consultants for the Indian Army from the civil side by allowing those who were first class physicians and surgeons to be promoted up to the rank of colonel only, without becoming administrative officers. If such promotion were limited to the rank of colonel, the ablest men, who were to attain the highest possible rank, would object to the limitation.

The leave difficulty had been the greatest cause of discontent among the Indian Medical Service. The reserve should be increased so as to enable officers to get leave to which they were entitled under the rules. They should also be able to get their study leave in normal times. The Indian Medical Service had suffered owing to the fact that the Director, Medical Services, was not appointed from that Service. Their grievances could be remedied only by having one unified service for the whole of India.

Indian candidates for a competitive examination held in India would be sufficiently qualified, but they should be sent for a year's training to England where they might obtain appointments as house surgeons. He admitted that their education in some special subjects was insufficient, and that they might devote themselves to such subjects as gynaecology, diseases of the skin, etc. The second half of the year in England should be spent at the Royal Army Medical College at Millbank.

If the prospects of the Indian Medical Service in the way of pay, leave, etc., were improved and their other grievances were removed the service might again become popular in England.

11 March 1919.]

Lieutenant-Colonel A. MILLER.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

No change was called for in the method of recruiting professors for the medical colleges. If the Indian Medical Service again became popular the present method would be the best.

Private practitioners could certainly not carry on the teaching work in the medical colleges as efficiently as Indian Medical Service officers were carrying it out at present.

(Colonel Bhola Nauth.) The residuary appointments mentioned in paragraph 13 of his written statement should not be struck off the list of the Indian Medical Service. No doubt they ceased to be a reserve for military purposes, but there was strong objection to these residuary appointments being thrown open to outside persons. This would spoil the Indian Medical Service and take away one of the chief attractions of the service.

Recruitment for the new service should be by open competitive examination in England and to a certain extent from India. It was for Government to say how many should be recruited from India.

His remark to the effect that Indians who joined the Indian Medical Service were of a lower social standing than the British officers in the service was based on Indian standards of social status, and not on the Indian standard which was different from that of the Europeans.

(Major Cramer-Roberts.) The minimum period of civil employment after which an officer should go for military training was five years. It would suffice if there were regular transfers for three months to the military after 5 years' service in civil. This would not cause any dislocation in the civil work.

(Mr. Hignell.) He would not fix any limit of service after which an officer should not go for military training, and would let officers even with 15 or 20 years' service go for this purpose.

(Sir T. Nariman.) The witness was the Principal of the Medical College, and was Professor of Chemistry and Medical jurisprudence.

The professorship of chemistry should be included among residuary appointments. Such posts even in England were held by medical officers and not by chemists, when medico-legal analysis formed an important part of the work.

The remark about deficient training in midwifery of Indian students did not apply to Madras. Students in Madras were generally well trained in the subject, and had good opportunities, though not so good as in England, of acquiring practical knowledge.

The position of the Indian candidates competing at the separate examination held in India would have to be determined by the final examination, say in Millbank, which would be the same for all the candidates. As there would be an entirely separate examination in India there would be no difficulty about the practical test. There was no danger of those completing at this examination being considered inferior.

(Mr. Hignell.) He would prefer the system of recruiting a certain proportion of officers by competition in India, to that of sending a number of students on scholarships to England. It would be possible to get the best men in this way. He had, however, no objection to the grant of scholarships to cover the expenses of education in England provided they were granted according to merit. At present most of the scholarships were mere stipends. He would not have any objection to a separate examination in India in addition to the system of scholarships.

(Sir T. Nariman.) Indian graduates were well qualified, but were of a much lower standing than European students entering the Indian Medical Service. They required more practical training in the atmosphere of the English schools. They lacked initiative. He had frequently recommended for appointments in the Indian

Medical Service Indians who were really capable persons, and had received their training in England.

(General Hendley.) The sub-assistant surgeons, both civil and military, should be abolished. If they could have a five years' course they would be as good as assistant surgeons. It would of course take time before this could be accomplished. To begin with there would be two grades of practitioners, but he looked upon the lower grade as an anomaly.

There should be a whole-time officer as principal and head of the hospital attached to the college. He should have the rank of colonel, and should have no other duties to perform except those of administering the two institutions which would be quite sufficient for him. He should not be allowed to carry on private practice, or even consulting practice.

(General Giffard.) One of the possibilities of a really unified service was that there would be a greater opportunity of exchange between the civil and the military. There would be nobody permanently in civil or military, all being in one service. If the transfers took place regularly it was possible for a medical officer to retain his professional capacity, and at the same time to be sufficiently well trained in military duties to be ready to take up military administration. Under this system there would be no need for an officer to say at a particular time that he wanted to go to the military. There would be the undoubted advantage that an officer who was thoroughly well trained professionally and had also received military training, would be far more efficient than the purely military officer. Both sides of the science would thus gain.

He was against the proposal to throw open the residuary appointments to the English speaking world as this would spoil the service, and remove one of the greatest inducements to enter the Indian Medical Service.

It was worthwhile for the Service to have these appointments as an attraction and to have officers working towards them during the whole of their service. They induced a better class of men to join the Service, and there was no use in removing them from the cadre. If this were not accepted it would not be possible to get eminent experts from Home at a reasonable salary. It would not be possible to get a fairly senior expert on less than Rs. 1,500 a month to start with. He would expect at least Rs. 2,500 after 10 years' service. The experiment would be a very costly one. Nor would this be an equally efficient arrangement. It would only spoil the Service without any counterbalancing advantage.

Military assistant surgeons might either be detained, as at present, or they might be abolished if Government did not consider them necessary. The former course was open to the objection that after about 10 years' service these assistant surgeons became discontented and were looked down upon as inferior. The latter course would result in shutting the door of medical education to Anglo-Indians, as most of them, being poor, would not be able to educate their sons up to the university degree. There would be only about 3 or 4 per cent. who might be in a position to do so. A large number of the Anglo-Indians were indeed very poor. If Government did not help them they would disappear from the medical profession. On the other hand if Government incurred all the expenses and educated them up to the degree standard, the danger was that they might leave the service or join the Indian Medical Service. With regard to the final question whether he would mend the military assistant surgeons, end them, or suggest some half-way measure, he replied that he would give them a five years' course, a good start and the L. M. S. degree at Government expense. They should, however, be required to serve Government for at least ten years.

DR. N. VENKATASWAMI CHETTI, M.B. & C.M., Private Practitioner, Madras.

Written statement.

After a most careful and anxious consideration of the schemes forwarded to me, I have come to the deliberate

conclusion that none of the four schemes could be accepted by an Indian. The schemes are so diametrically

11 March 1919.]

Dr. N. VENKATASWAMI CHETTI.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

cally opposed to the interests of the Indian medical graduates and so obviously one-sided that it is surprising that such schemes should ever have been thought of.

I must also protest against the constitution of the present committee. It is surprising to note that a committee whose duty is to consider the momentous questions concerning the re-organization of the medical services should consist only of representatives of the two military services, the Royal Army Medical Corps and the Indian Medical Service, with a civilian officer to preside. It seems to me the exclusion of the representatives of the civil medical service and of the very large and influential class of private practitioners and of the general public is so great an omission that no unprejudiced public man will place any confidence in the findings of such a committee. I am forced to inform the authorities concerned that the impression amongst Indian medical men and the general public is that such a committee savours of a trade guild constituted with the idea of benefiting the two services whose members are represented therein.

Is the war reserve needed?—To appreciate this question of war reserve at its true value, it is necessary that we should try and understand what the practice is in other countries. The medical needs of the British Army are met by the Royal Army Medical Corps, a body of men selected in almost the same manner as the Indian Medical Service, through a competitive examination. Now there is no war reserve for the Royal Army Medical Corps. Nor is there a war reserve for the Navy Medical Service. Nor is there a war reserve either for the Colonial Medical Service or in the army of the United States of America. What then is the object of this war reserve in India alone of all countries? The evidence of the late Sir Pardey Lukis throws some light on the subject. He maintained that a war reserve was needed for the following reasons:—

- (1) If India were at war on a large scale rendering a general mobilization necessary there was little doubt that Great Britain should also be at war and in that case the troops at Home and the territorials would absorb every available civil practitioner and there would be none left for India.
- (2) The number of medical men was limited in England and many from there could not be spared.
- (3) It was almost impossible to obtain a reserve from the medical profession in India. The few Indians who hold European qualifications or the higher Indian qualifications had all large and lucrative practice in the big cities and they will not give up their practices to serve in the army in the field.
- (4) A large number of the Indian practitioners belonged to the non-martial races and should therefore be unsuitable for the army.
- (5) In order to ascertain how many qualified men would be available as volunteers in the event of a war, a reference was made in 1913 through India and it was found that only 24, all Europeans, were willing and most of them were old men.

These facts Sir Pardey Lukis thought justified his holding the opinion that the war reserve was very essential. The last statement was challenged by the late Mr. Gokhale and Sir Pardey Lukis admitted that unless it was known what efforts were made to invite Indians to volunteer and the terms that were offered them, the mere fact that the 24 men who volunteered were all Europeans could not be conclusive as an argument that no Indian would be available. How far from the real state of affairs Sir Pardey Lukis was, will be evident to any one who reads the history of the time; and fortunately for the Indian medical man, his patriotism, his manliness and his eager desire to do his duty have been subjected to a very great searching test and he has come out of the crucible of the greatest war in history quite unscathed and with flying colours. Little did Sir Pardey

Lukis think that in the short space of three years not 24 but a hundred times that number would be eager to stand up for King and Country prepared to meet any sacrifices required of them.

Let us next examine how far this war reserve was utilized during recent times. Sir Pardey Lukis has stated that for the past 35 years prior to this great war, *i.e.*, since the Afghan War of 1878-80, the war reserve was called up only twice: seventy-six officers were for the North-West Frontier Expedition of 1897—98 and 87 for the China Expedition of 1900: that is to say less than 100 officers were called up during the past 35 years and that only twice for brief periods.

It is a curious fact that whereas in 1887 the war reserve of the Indian Medical Service consisted of 299 officers in civil employ, in 1913 in spite of the reduction in the army the war reserve had swelled up to 475 officers in civil employ.

The war has shown conclusively that no amount of war reserve is of any value and that the best and most economical method of finding a war reserve is to depend on the patriotism and the intelligent co-operation of the people of the country. In response to the call, hundreds of young medical graduates have volunteered for military duty from this country and if the response was not earlier it was due to no fault of theirs. We learn that nearly 900 Indian medical graduates have been given temporary commissions in the Indian Medical Service. The second lesson of the war is probably the unexpected but not surprising breakdown of some high officials in the Medical Department who were hardly fit for such high military commands after years of benumbing civil life. The Mesopotamia muddle is too fresh in the minds of all to be referred to at greater length. Thirdly, the war, strange as it may seem, has given an unprecedented opportunity for the Indian medical graduate not only to show his practical patriotism by volunteering in such large numbers but what is just as important to demonstrate his capacity and his intellectual ability to hold some of the highest medical posts in the country. Reports are to hand from all quarters to show that the assistant surgeons who have largely replaced the Indian Medical Service have acquitted themselves in a manner which has surprised friends and confounded foes. Of the many such testimonials I shall quote but two:—

Surgeon-General W. R. Edwards, Inspector-General of Civil Hospitals of Bengal and now Director General, Indian Medical Service, in his administration report of 1915 says "the places of the Indian Medical Service civil surgeons have been filled by retired officers to some extent but chiefly by the temporary promotion of civil assistant surgeons of the Provincial cadre. I am glad to say that all these officers have worked conscientiously and discharged their duties of appointments in an efficient manner and that as far as can be judged from the result of the past year's working the popularity and usefulness of the medical institutions have not materially suffered under the altered arrangements."

In the Presidency of Madras which has been practically denuded of all the Indian Medical Service officers in civil employ and where the members of the provincial medical service are in charge of almost all the districts formerly held by the Indian Medical Service officers the medical relief has been so successful that the Government of Madras in their review of the report of 1916 (G. O. no. 406, dated 24th September 1917) have paid the following generous compliment: "The most noticeable point in the Surgeon-General's report is the increase in the amount of work done in spite of the depletion of the staff of all ranks. Less than a third of the ordinary establishment of Indian Medical Service officers remain in civil employment and in the past year especially it has been impossible to keep all the dispensaries open continuously owing to the shortage of sub-assistant surgeons but the attendance has gone up almost everywhere. Hospitals both in Madras and in the mufassil have been short-handed but have been kept going by the exertions of the officers in charge and the number of patients treated and the number of operations performed have been larger than ever before while the death-rate has been lowered."

11 March 1919.]

Dr. N. VENKATASWAMI CHETTI.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

All these considerations have led me to submit a scheme which is different from any of the four schemes suggested.

In the scheme that is herein proposed, the needs of the military and of the civil population only have been taken into consideration. Obviously the vested interests of the various services ought to find a place of secondary importance.

The military medical service.

The superior service will consist of members of one unified medical service which will be recruited at an open competitive examination held simultaneously in England and India to which all medical men whether Indian or European should be admitted if they hold a medical qualification registrable in England. After selection those recruited in India may be sent to England for training by the Government for a definite period.

The experience of this war warrants the conclusion that there is no need to restrict either the European or the Indian to regiments of their own class but both may be allowed to look after either with the least discomfort. Such an arrangement would answer best the needs of a combined military hospital for Indian and European troops.

If such an arrangement be not acceptable to the War Office, and I for one do not see any reason why it should not be accepted if there is any truth in the changed "angle of vision" and the talk about ties of friendship cemented on the battlefield by the shedding of blood for a common cause, the only other alternative is to restrict the European to the British troops and the Indian to the Indian troops.

The subordinate personnel should consist of—

1. Anglo-Indian military assistant surgeons.
2. Indian military assistant surgeons composed of the present sub-assistant surgeons whose pay and prospects should be so improved as to make them comparable to that of the Anglo-Indian military assistant surgeon; the term sub-assistant surgeon should be deleted and they should be styled Indian military assistant surgeons.
3. Nursing section of Royal Army Medical Corps as at present.
4. A similar Indian Hospital Corps for Indian troops.

Conditions for civil employment.

It must be clearly laid down that officers recruited for the military have no grounds to look for civil posts and that their normal field of activity is in the military department.

Officers for civil medical service.

The civil medical service shall be composed of—

1. Superior grade. { Class I.
Class II.
2. Subordinate grade.

The superior grade shall be composed as follows :—

Class I consists of 50 per cent. filled by an open competitive examination held in India to which Europeans and Indians who hold registrable qualifications will be admitted; age limit being 35.

Fifty per cent. of the posts will be filled by promotion from *Class II*.

Class II will consist of medical officers who are styled assistant surgeons at present. The recruitment for this class shall be the same as exists at present for assistant surgeons. Ten per cent. of the vacancies in this class should be reserved for men from the subordinate medical service who have put in 14 years' service, selection being made for merit. Officers in *Class II* will be eligible for promotion to *Class I* after 14 years' service but in the case of promoted medical officers a total service of 20 years is enough.

Subordinate grade.—This shall be filled by the class of medical officers known as sub-assistant surgeons but this term should not be applied to them.

Professorships, chemical examinership, and alienist appointments and other special appointments which require special knowledge or special merit should not be included in the ordinary cadre of the superior civil medical service but should form a separate branch. These posts should be filled by specialists who have established a reputation for original work. They need not be selected from any service but should be the best men available in India or in England. Their salaries should be liberal so that the best men may be attracted to these posts and economy in this line would be a false economy.

The professorships of physiology, anatomy, chemistry and biology shall be for whole-time men who are debarred from private practice and they should be given suitable allowances. The professors of other subjects shall have only consultation practice.

The administrative organization which will be best suited to the scheme would have to be determined by the Government. Probably a provincial organization will be most convenient and should be the one adopted in view of the proposal to grant provincial autonomy. If, however, the organization be imperial then the Director General under this proposal will naturally be of the entire service and not as at present solely of the Royal Army Medical Corps or Indian Medical Service.

So far as the Surgeons-General of the presidencies are concerned, the appointment should ordinarily be made from civil medical service. The present practice of reserving these appointments to members of the Indian Medical Service has led to the head of the department identifying himself more often with the interests of his service to the detriment of the other services.

All the officers of the civil medical service should form the war reserve and should be called upon for military duty in case of necessity. They should be given an initial and periodic military training so that they may be fit for military duty.

Officers of *Class I* of the civil medical service when called upon for military duty should be given temporary military rank corresponding to the length of their service. Officers of *Class II* should be given at least the rank of a lieutenant when on military duty.

The officers holding special appointments do not come under this reserve.

The selection of officers for these special appointments should be left to local Governments who will consult an All-India Advisory body which shall be formed by an equal number of Indians and Europeans. The advisory body so formed will keep in touch with the deans of the medical faculty in the United Kingdom and India with a view to find out suitable candidates for these posts.

Special research department.—This department should be separate from either of the two and should be an Imperial department under the Government of India, officered by medical men of research fame from any country. Their emoluments should be liberal so as to free them from all pecuniary cares and they should be allowed sufficient latitude to visit other countries in the interests of their research studies. To these officers I would attach a sufficient number of our best medical graduates as research scholars so that they may be trained in the proper atmosphere and endow themselves with the knowledge necessary for carrying on research independently later on.

Provision for treatment of women and children.—It seems to me that in discussing this question arguments of racial prejudice should not play any prominent part whatsoever. If the European could afford to bring forward this question of racial prejudice and argue on that basis that a European medical officer should be posted to every military station and every civil district headquarters, it would be equally competent for the Indian to argue that his ladies and children should not be forced to go to hospitals which are mostly if not entirely managed by European medical officers. If the racial argument be pushed to its logical conclusion, the European may as well argue that a European medical officer should be attached to every single European family in this country with as much reason as he now argues for a European medical officer for the few Europeans employed in the district.

11 March 1919.]

Dr. N. VENKATASWAMI CHETTI.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

I would invite the attention of the committee in this connexion to the very lucid and well reasoned answer of the Hon'ble Mr. Justice Abdur Rahim in his valuable minute of dissent to the report of the Royal Public Services Commission. He writes "Stress was laid before us upon the necessity of providing European doctors for the families of the European employes of the Government as they do not like to be treated by Indian practitioners. Undoubtedly the prejudice alluded to exists; at the same time I believe that it is somewhat exaggerated. We were told by more than one Indian practitioner that there were always some Europeans who felt no difficulty in calling in the assistance of Indian medical men for their families and it may be taken that the number will grow and not decline. However, that may be, if the argument on the European side is sought to be pushed to this length that because there happens to be one or two European officials in a district, the State must provide them with a European doctor or a member of the Indian Medical Service it is *prima facie* unreasonable and cannot be admitted to override the larger interests of the country and of the general population. The demand must be limited to more reasonable proportions. If it is to be so limited and the following facts are borne in mind, namely:—(1) that in all large cities there are always some European medical practitioners, (2) the rapid growth of the medical mission, which often works in the district, (3) the number of military stations where there are military medical officers, (4) the spread of railway communications, (5) the fact that the families of European officials often spend the unhealthy part of the year in hill stations and a number of them live in Europe, (6) the number of districts which are likely to be manned by Indian officials, the real requirements would be fully met by a small fraction of the number of Indian Medical Service officers employed in the civil departments. The number which I am proposing taking also into account the number of Anglo-Indian doctors who will be available will amply meet the requirements."

I would only add one more reason to this summary, namely, the creation of the women's medical service and the larger employment of lady doctors now seriously under contemplation makes it even more unnecessary to provide any special officer for European families.

The Indian and European medical graduate.—I deem it my duty to enter my protest against the attempt to make it appear that the Indian medical graduate is in any way inferior to the European medical graduate. The evidence given before the Royal Commission by several European officers who were for long professors in the various medical colleges is enough to give the lie direct to any insinuation as to the inferiority of the Indian medical graduate.

The late Sir Pardey Lukis, who was for many years Principal of the Calcutta Medical College, in the course of his evidence (paragraph 56375) said "The standard of medical training in Indian medical colleges was as good as and in many ways better than that in England," and also "that the Indian colleges were as good as and in many ways better than the English colleges." He considered the degree an Indian obtained in an Indian university was of the same value as that obtained in an English university and the General Medical Council recognized it as a registrable qualification.

The evidence given by Colonel Harris, Sir Leonard Rogers and Surgeon-General Lyons, shows conclusively that the Indian medical graduate is as good as the English medical graduate.

Assuming for a moment that it is a fact that the Indian medical graduate is inferior to the English graduate and that he must spend some years in England and get an English qualification to make him eligible for applying say, for the Indian Medical Service the inference is obvious that the fault, if fault there be, is not with the material but with those entrusted with the task of moulding that material, i.e., the staff of the various medical colleges as recruited at present. Since my scheme proposed a different and better method of recruiting the professorial staff, this defect will be remedied.

Medical education.—I think it is time that there was a radical change in the present method of imparting medical knowledge. The present L. M. P. standard should be so improved as to bring it on a line with the diploma of the Royal Colleges and then the licentiates of these schools and the graduates of the university should be allowed to compete for all three classes of the civil medical service. Specialisation in the various subjects has not been attempted at all in this country and efforts should at once be made to open special hospitals and special courses should be instituted for the various branches of the medical science.

Such in brief is the scheme which I think is best suited to the needs of the country at present. It is necessary for us to have a broad outlook and to take note of the altered circumstances and the change in the angle of vision. The Indian medical graduate, alone probably amongst the educated classes of this country, has been given the opportunity and has fully availed himself of such opportunity to show his practical patriotism and high sense of duty. He has every right to demand, therefore, that in recognition of the meritorious services rendered by him during this war he must be given a fair share in his own country. The fact that 900 Indian medical graduates joined the military voluntarily and with no pressure out of a total strength of about 2,000 ought to be enough to silence all critics who used to speak disparagingly about the Indian medical men.

Q. 1.—What defects have you noticed in the organization of the Royal Army Medical Corps and the Indian Medical Services in India? Does any one of the attached schemes, which are suggested with a view to remedying existing defects, commend itself to you and if so, which and why?

A.—I have no remarks to make about the Royal Army Medical Corps.

With regard to the Indian Medical Service the defects noticed are—

(a) The employment of the Indian Medical Service in the civil has led to the inefficiency of these officers when transferred to military. Military officers must be confined to the military and should not be drawn into the civil. The Mesopotamia report fully bears out the truth of this statement.

(b) The reserving of professorial posts to the members of the Indian Medical Service has led to the appointment of men not suited for these posts. At present the officers of the Indian Medical Service themselves seem so dissatisfied with their teaching that they propose to send the Indian medical students to England to get a better training.

None of the attached schemes commends itself to me as the rights of Indian medical graduates have been completely ignored.

Q. 2.—Do you consider that the scheme which you commend will meet with the approval of the War Office, and that it will meet the needs of the army in India? Have you any criticism to make in either connexion?

A.—I see no reason why it should not meet with the approval of the War Office. It fully meets the needs of the army in India.

Q. 3.—Do you consider that the scheme which you prefer will attract a good stamp of recruits and meet the demands of professional opinion in England and in India? If the scheme which you prefer fails in either respect, how would you remedy such failure?

A.—Yes. I do.

I do not know what is meant by the demands of professional opinion in England and I do not see the bearing of this on the re-organization of the Indian medical services. It will, I think, meet the demands of professional opinion in India.

Q. 4.—What has been the result of withdrawing European medical officers from charge of troops, civil districts and jails in India?

A.—So far as I can see from a perusal of the administration reports of the various provinces and from my own experience, the medical administration of the country

11 March 1919.]

Dr. N. VENKATASWAMI CHETTI.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

seems to have been carried on just as efficiently without the European medical officers. The result of withdrawing the European medical officers has been that it has proved the capacity of the Indian medical graduates to replace the European medical men without any loss of efficiency and with greater economy.

Q. 5.—Will the scheme which you recommend meet the needs of the civil administration in India? To what extent would it be affected by needs occasioned by war on a large scale?

A.—Yes, it would. It would stand the strain of war on a large scale better than any of the other schemes suggested.

Q. 6.—Would the scheme which you recommend give a sufficient and efficient reserve for military purposes? If not, how would you supplement it?

A.—Yes. The war reserve would be quite efficient and I hope also sufficient.

Q. 7.—Do you consider that it is necessary to have a medical service for war previously trained in military work, and must such reserve be always actually present in India?

A.—Yes. Certainly the reserve ought to be in India.

Q. 8.—How far has the Indian Medical Service reserve (civil side) proved of value in the war?

A.—My information is that the war reserve of the Indian Medical Service was not a success in this war.

Q. 9.—What system of recruitment and education do you recommend as desirable for medical officers in connexion with the scheme which you prefer?

A.—Vide my scheme.

Q. 10.—Have you any suggestion to make as to the grant of special leave for study or as to prescribing periods of study?

A.—Special leave for study up to the period of one year should be available for all classes of officers.

Q. 11.—Have you any suggestions to make as regards the provision of a special department for research?

A.—Yes. Vide my scheme.

Q. 12.—How far has private practice declined in the case of officers of the Indian Medical Service in civil employ? If it has declined what are the reasons?

A.—It has not declined to any extent in the case of those officers who are holding special appointments in the city of Madras. In the mufassil there may have been a slight decline owing to the increase in the number of private practitioners and service men of better quality, but I must add that the Indian Medical Service officer in the mufassil never had much practice at any time. I may add that Indians naturally prefer their own countrymen to treat them except when they have to resort to European medical officers just as, I am told, Europeans prefer their own countrymen to treat them.

Dr. N. VENKATASWAMI CHETTI, called and examined.

(General Giffard.) He did not think that Indians would accept any of the schemes put forward as they were all one-sided, and were opposed to the interests of Indian medical graduates. Taking into consideration the services rendered by Indian graduates recently, he expected more of them to be admitted into civil employ.

Statistics showed that 900 medical men volunteered for military duty. His information indicated that the majority of them were young graduates who might be called private practitioners. In the beginning of the war when a general call was made on private practitioners he and a good many others volunteered for military duty but they were informed that in case of necessity they would be asked to volunteer later on. They did not hear anything for about a year. After a year Dr. Nair sent a private communication to some medical men asking them if they were willing to volunteer again. He could not make an authoritative statement as to the number of private practitioners who volunteered, but certainly more than a hundred had done so.

His scheme provided for the needs both of the army and of the civil population. Military officers would be confined to the military department and to the charge of troops, and civil officers to civil duties. By his proposal military officers when called upon to do their proper duty in times of emergency would be better fitted to that portion of the work than officers transferred from civil. The civil medical officers would form the war reserve and they would be given a course of initial and periodic military training so that they may be fitted for military duty.

With reference to the difference between his ideas and those set forth in scheme B, witness stated that his idea was that recruitment should take place in India, as this would give a better chance of more local graduates getting into the service.

He was in favour of a competitive examination being held simultaneously in England and India, or, if there was any difficulty about this, there should be one examination and this examination should be held in India. In the case of those who were undertaking a course in England witness stated that they would have to come to India, as this would be their final destination.

(General Hendley.) Europeans wishing to enter the service would have to come to India to compete. They would not be excluded.

It would not necessarily be an Indian service. He would call it the Indian civil medical service. He did not think Europeans would object to come out and sit for an examination held in India if they were really anxious to serve in India.

The opinion expressed in his written statement with regard to high officers who had spent the most of their time in civil not being fit to hold military commands was taken from the Mesopotamia Commission report. He did not know who was responsible for the medical arrangements in Mesopotamia.

(Sir T. Nariman.) If the present day medical institutions and colleges in India were manned by a better staff of officers, and the number of medical colleges increased, there would be no difficulty in producing good men who would be fit for the service. Specialists should be appointed to all professorial chairs. A reference to the Principal of the Medical College in Madras would elicit the fact that out of 100 applicants who seek admission to the college only about 60 to 80 are admitted. This shows that if there were more colleges more men would be able to obtain admission.

There was not much difference in the quality of the Home trained graduate and the Indian trained graduate.

(Lieutenant-Colonel Bhola Nauth.) The civil assistant surgeons who had largely replaced the Indian Medical Service officers in civil had done remarkably well. He would not admit that the civil assistant surgeons had proved a failure on the military side on the whole. He knew of some Indian Indian Medical Service officers who had been rewarded for field service. There might have been a few cases where they had failed.

Recruitment for the civil side of the service should be carried out in India, but he had no objection to people from England competing. He agreed with the opinion that there should be a British standard of education in India, and that the prestige of Indian doctors should not be lowered.

The appointment of officers to administrative posts should be left in the hands of Government; the officers appointed to such charges should come out of classes 1 and 2, referred to in his written statement.

(General Giffard.) He thought there would be no difficulty in obtaining some private practitioners to form a war reserve as there were a number of patriotic men to be found.

11 March 1919.]

S. BALASUBRAHMANYA NADAR.

(The schemes and questions referred to by witnesses are contained in Volume III.)

Senior Grade Civil SUB-ASSISTANT SURGEON S. BALASUBRAHMANYA NADAR, Government Maternity Hospital, Madras.

*Written statement.**Questions for military and civil sub-assistant surgeons.*

Q. 1.—Are you satisfied with your present position as an Indian warrant officer? If not, give reasons.

A.—As I am a civil sub-assistant surgeon, I cannot answer this question.

Q. 2.—Do you consider that study periods would be important to your branch of the service, and if so, should they be taken in—

(a) existing medical colleges, and

(b) a proposed new military medical college in India?

A.—By 'study periods' I understand 'leave granted for the purpose of enabling sub-assistant surgeons to follow a course of theoretical study in a medical college.' I am of opinion that as sub-assistant surgeons are already well grounded in all branches of theoretical studies before they are taken on service, they need not as a body be obliged to follow another course of study after they have entered service. 'To be a successful practitioner, practical experience is all in all. In order to enable all sub-assistant surgeons to acquire practical experience in up-to-date methods of treatment, it is essential that they should be required, after they have put in, say, ten years' service, to work for a year or two in the General Hospital, the Maternity Hospital and the Ophthalmic Hospital in Madras. I am of opinion that such a practical training will be of greater benefit to the service generally than mere theoretical study in a medical college. But I will not object to individual sub-assistant surgeons of proved merit being granted study leave to follow a higher course of studies in a medical college so as to qualify themselves for appointment to the gazetted ranks.

Q. 3.—Should the local governments decide to throw open civil appointments to a large number of military sub-assistant surgeons, do you think such appointments will be popular and sought after?

A.—I understand that the appointment of military sub-assistant surgeons is not at present popular because—

- (1) these officers are not treated as commissioned officers,
- (2) they have to live in barracks away from their relations and native districts, and
- (3) they lose private practice.

It is not by throwing open civil appointments to a large number of them that such appointments will be rendered popular and sought after. The result of such a proposal will be that the number of civil men required for the civil appointments will have to be correspondingly reduced and, when in time of war all military men are called up, there will be numerous civil appointments unfilled and the public will suffer for want of adequate medical aid. The best method of rendering military appointments popular and sought after is to raise the subordinates to commissioned ranks, to make their leave rules less stringent, to grant the men pay, allowances and pension on a more liberal scale than at present. If a war reserve is considered necessary, it should be provided in the cadre of the civil sub-assistant surgeons and it will be seen from my answers to questions 6, 8 and 15 that there will be no difficulty in obtaining the services of an adequate number of civil sub-assistant surgeons in time of war.

Q. 4.—Do you consider that military and civil sub-assistant surgeon pupils should have a higher preliminary school or university qualification than they do at present?

A.—I do not think that the pupils need have any higher preliminary school or university qualification than they possess at present. A sound knowledge of English is very indispensable and I would prefer school

final candidates who have taken chemical science as one of their group subjects to others. In order, therefore, to make a suitable selection of candidates for the service, I would suggest a departmental selection examination in English and chemical science. My suggestion implies that students who propose to enter medical service should take up chemical science as their group subject, English being, of course, compulsory, for their School Final Examination.

Q. 5.—What will be the effect on recruiting for the military sub-assistant surgeons and civil sub-assistant surgeons classes of demanding a security deposit of money before commencing training; which deposit would lapse to Government if the sub-assistant surgeons fail to complete the necessary five years' service?

A.—So far as I know there is no professional department of Government such as the Public Works Department, Agricultural, Veterinary, Forest, etc., which requires a deposit from the candidates as a pledge of fulfilling the conditions of service. If such a deposit is required the effect on recruitment for both classes will be disastrous.

Q. 6.—Is the bond now signed satisfactory, under which civil sub-assistant surgeons may be drafted to military employ during or after five years' civil service?

A.—I am of opinion that to secure the object in view, the conditions of the present bond are adequate and satisfactory but in order to safeguard the interests of the department, I would suggest that an additional bond be taken from two sureties who will hold themselves responsible for the repayment to Government of the amount entered in the bond executed by the civil sub-assistant surgeon in case of refusal on his part to be drafted to military duty in India. It may be stated in the bond that refusal will also mean dismissal from service.

Q. 7.—Is service with the army under present conditions satisfactory to civil sub-assistant surgeons, and if not, what remedies do you suggest?

A.—I have no personal knowledge to answer this question.

Q. 8.—If Government propose that all civil sub-assistant surgeons should undergo a course of military training, will this be popular in your department and will it affect recruiting?

A.—As all civil sub-assistant surgeons are, under the bond, bound to be drafted to military duty in India (*vide* my answers to questions 6 and 15), I consider it essential that they should be required to undergo a short period of military training during the first five years of their service. Such training will not be so unpopular as for instance, service in the Agency tracts, and will not affect recruitment.

Q. 9.—Are you satisfied with your present scale of pensions?

A.—As all civil sub-assistant surgeons are to be drafted to military service, I think it is necessary that, for the purposes of pension, they should be placed on the same scale of pension as may be offered to military sub-assistant surgeons.

Q. 10.—Do you consider that there should be a scheme of pensions for widows and orphans of both military and civil sub-assistant surgeons, if so, would the sub-assistant surgeon be prepared to contribute?

A.—Yes. The scheme, if introduced, will be welcomed by my service.

Q. 11.—Are there any other specific disabilities in your service which you desire to bring to the notice of the Committee?

A.—I desire to bring to the notice of the Committee the following disabilities in my service:—

- (1) The rule that requires civil sub-assistant surgeons to pass a departmental examination for grade promotions is not considered necessary

11 March 1919.]

S. BALASUBRAHMANYA NADAR.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

and encouraging. It is not, so far as I know, in force in any professional department of Government, such as the Public Works Department, Agricultural, Veterinary and Forest.

- (2) Although the scale of pay of civil sub-assistant surgeons has recently been revised and increased, it will, I think, be made more attractive if they are placed on a par with subordinates of similar status in other departments, such as—
- (a) Deputy tahsildars and tahsildars who draw Rs. 100 rising to Rs. 250.
 - (b) Upper subordinates in the Public Works Department (overseers and sub-engineers) who draw Rs. 60 rising to Rs. 300.
 - (c) Forest rangers who draw Rs. 50 rising to Rs. 150 or more.
- (3) Frequent transfers are detrimental both to Government and to sub-assistant surgeons. No transfer should take place until they have served for at least five years in any one locality. This does not apply, however, in the case of necessity for transfer either for misconduct or for health reasons.
- (4) At least one-third of the total strength of assistant surgeons should consist of sub-assistant surgeons of proved merit.

Q. 12.—Have you any suggestions to make regarding the present method of recruiting for your service?

A.—As regards the type of men to be recruited for the service and the method of selection, I have already offered my views in my answers to question no. 4.

Recruitment should, as far as possible, be general except in cases where there is a real need for a larger percentage of recruitment from any one community.

DR. S. BALASUBRAHMANYA NADAR, Madras, called and examined.

(General Giffard.) The present four years' course of training for sub-assistant surgeons was considered quite sufficient.

The sub-assistant surgeons need not have any higher preliminary qualification than they possess at present. The present school final examination would suffice. By this it should not be understood that every one who had completed the school final course was eligible for admission into the medical school. Admission should be restricted only to those who had secured such marks in the school final examination as would enable them to get an entrance into the intermediate.

The pay of sub-assistant surgeons was fairly good now. Formerly it was much worse. Despite the increase that was recently given them, they were still considered to be inferior in social status because of the low pay which they were getting. They might get more than Rs. 100 or Rs. 200 a month in private practice, but that did not in any way enhance their social stand-

ing. The sub-assistant surgeons might be given a further increase in their pay in order that they might be placed on a level with the subordinates of other similar departments.

Q. 13.—As a warrant officer have you any difficulty at present in connection with the maintenance of discipline in regimental or Indian station hospitals?

A.—I have no personal knowledge to answer this question.

Q. 14.—What would be the effect on the civil sub-assistant surgeon service if the wearing of uniform and other military privileges and disabilities that would affect sub-assistant surgeons if they were brought under the Army Act when serving in military employ?

A.—I am unable to answer this question fully as I do not know what the "other military privileges and disabilities" are, but I am of opinion that the wearing of uniform when on military duty would effect in that it would entail expenditure in making such uniform. There will be no objection if Government provide uniforms.

Q. 15. What would be the effect on the civil sub-assistant surgeon service and on recruitment for that service of making field service in time of war one of the conditions before the employment in the civil medical service.

A.—The introduction of this condition will not only have an injurious effect on the civil sub-assistant surgeon service but will affect recruitment. It will be sufficient if it is clearly stated that in cases where military sub-assistants are sent on field service (out of India), civil sub-assistants must be prepared to take their place in India. In the case of casualties among military sub-assistant surgeons on active service (out of India) the gap should be filled in by civil sub-assistant surgeons doing military duty in India on condition that they be granted the same pay and privileges as the military sub-assistant surgeons on active service enjoy. If this drafting of civil sub-assistant surgeons to field service (out of India) is necessary I would suggest that men of more than twelve years' service should not be considered.

He was in favour of study leave being granted to sub-assistant surgeons, after they had put in some 10 years' service. They should not, however, be compelled to take such leave. But there was no objection in compelling sub-assistant surgeons to take a practical course in a hospital. An examination might also be held at the end of the course but promotion should not depend upon passing the examination. He would rather leave the promotion in the hands of the head of the department who was acquainted with their professional ability, etc.

(General Hendley.) Personally he was satisfied with the designation "sub-assistant surgeon," but his colleagues desired that it should be changed.

DR. A. LANKESTER, M.D. (Lond.), Director, His Exalted Highness the Nizam's Medical and Sanitary Department, Secretary, Medical Missionary Association of India.

Written statement.

In any scheme for re-organization which may be proposed I feel that due weight should be given to the importance of preserving the continuity of the Indian Medical Service. The traditions of a great service constitute an invaluable practical asset and should be passed on unbroken if it is in any way possible to do so. The apparent failure to secure this continuity is, in my opinion, a great objection to scheme A. There has been, as is well-known, for many years a serious lack of confidence on the part of Indian Medical Service officers as regards the future of their service. It would probably be far easier to restore this confidence on a

basis of adequate reforms to the existing organisation than on one involving complete loss of continuity.

All the schemes seem to have been drawn up too exclusively from the army point of view, the necessity of a civil medical service being apparently assumed rather as a means of maintaining an army reserve than as an essential element in the civil administration of the country. This is the conception which has obtained in the past and which of course explains the actual origin of the civil medical service in the country. In spite, however, of the experience of the war I agree with the report of the Public Services Commission in

11 March 1919.]

Dr. A. LANKESTER.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

believing that in the future "the medical needs of the army and of the civil administration should be calculated separately on their merits and a purely civil medical machinery should be created to meet the requirements of each civil medical department."

I do not believe that the events of the war have provided any valid argument against this recommendation although of course they will dictate the method and degree to which the officers of any such civil organization should be trained so as to provide the necessary medical war reserve. Our position in India depends on efficiency of administration no less than on military strength and an adequate organization for the supply of medical and sanitary needs is a vital part of good Government. The author of scheme B in opposing this position mentions the present fact of there being 800 temporary commissioned officers in the Indian Medical Service as a proof of the need of the trained army reserve. The same fact might equally be urged as a proof that a civil medical service does contain so large a body of men capable, after a very short period of training, of rendering effective military service.

In reply to the questions proposed for special consideration I may mention at the outset that I have had practically no inside experience of service matters and will therefore not deal at all with details in organization, etc., confining myself merely to general impressions which I have gained from observation:—

1. There has been far too much separation between the Royal Army Medical Corps and the Indian Medical Service and too little co-operation between the officers of the two services. The necessity for bringing the two more closely into co-ordination will, of course, be emphasized now that the Indian regimental system is being given up in favour of Indian station hospitals. It will be in the future far more even than in the past a serious waste of energy to have one set of officers dealing entirely with the needs of the British Army and another limited to those of the Indian Army. The loudly expressed discontent amongst officers of the Indian Medical Service during recent years and the steadily increasing failure of that Service to attract the best men from the schools at Home points clearly to defects in organization which, if not remedied, must sooner or later lead to disaster. The younger men in pre-war days complained much at the increasing length of the time which they were obliged to spend in the uninteresting routine of peace military duties before they could obtain transfer to the civil side. This period was frequently as long as 7 or 8 years and was complained of as occupying the years when a keen officer was most anxious for interesting practical work in his profession.

On the civil side, without going into details it has been generally recognized that the medical and sanitary needs of the country are far greater than can be met by the existing civil medical organization, although opinions differ as to how far it is the duty of Government to bring medical relief within reach of the whole population of the country.

As regards the schemes suggested, the one which gives prominence to the importance of maintaining the continuity of the Indian Medical Service is scheme C and I agree with paragraphs 2 and 3 of that scheme which read as follows:—

2. There should therefore as at present be two medical services:

- (a) The Indian military medical service.
- (b) The civil medical service.

3. Although these two administrations should be distinct they are to a certain extent complementary to one another and it is suggested that this inter-relationship should be maintained, the military administration keeping in view the needs of the civil medical service and the Government of India and the provincial governments remembering the medical requirements of the army in India. This reciprocal co-operation should be fairly elastic.

In working out the details of his scheme, however, the author of scheme C adheres to the principle of making the civil organization quite subordinate to that of the army, and I feel sure that the personnel of his "Civil medical service" would fall short of what a really efficient and adequate civil medical organization would require. Scheme C makes all officers destined for civil employ enter the service, *via* the army branch, making, however, five years the limit within which transfer to civil employ should be made; and it prescribes in place of continuous service in civil the return of officers to military service after five years in civil employ, until the rank of lieutenant-colonel is reached when permanency in one branch or the other may be hoped for.

I believe that the recommendations of the Public Services Commission alluded to above may be made practically effective and the continuity of the Indian Medical Service as a dual service attained, together with adequate provision for the needs of the army, by an arrangement by which (as regards superior personnel) schemes C and D would be amalgamated.

The present Indian Medical Service would as at present consist of two branches, army and civil, but these, though still closely co-ordinated would be made more distinct from each other. We may call them:—

1. Indian army medical service, I. A. M. S.
2. Indian civil medical service, I. C. M. S.

The Indian army medical service would include—

- (i) Present Indian Medical Service officers electing for permanent army employ.
- (ii) European and Indian medical men admitted direct by open competition in the United Kingdom for permanent army service.
- (iii) Royal Army Medical Corps officers seconded for duty with Indian army medical service.
- (iv) Royal Army Medical Corps officers permanently transferred to Indian army medical service.
- (v) Promoted military assistant surgeons.

The Indian civil medical service would include:—

- (i) Indian Medical Service officers electing for permanent civil employ.
- (ii) Indian Army Medical Service officers seconded for temporary civil employ.
- (iii) Direct admission by open competition of European and Indian medical men for permanent civil employ.
- (iv) Promoted Indian civil and military assistant surgeons.
- (v) Possibly in special cases European qualified men of a professional and social standard equivalent to those in (iii) whose experience may fit them for special posts.

Regarding clause (iii) of the Indian civil medical service, I am in agreement with paragraphs 4 and 5 of scheme D and also with the remaining paragraphs of the same scheme regarding the general personnel.

The outstanding feature of this arrangement is that a medical man would be free at the outset of his career to choose what that career should be, and to set himself from the first to equip himself accordingly, without having his time occupied and his professional course interrupted by periods spent in employ other than that of his choice. The advantages of this both for the officer and the service, whether army or civil, is too obvious to need elaboration.

I do not suggest that the present five years' interval between hospital appointments at Home and practical civil work in India is by any means time wasted. The discipline and experience of army work will doubtless be useful in the future. I do believe, however, that the same five years would be used to immensely greater advantage with reference to the future if spent at one of the large headquarter stations in a city hospital or in district work under the supervision of an experienced senior officer. An efficient civil organization should provide more than is done at present for the association of

11 March 1919.]

Dr. A. LANKESTER.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

junior officers with senior whereby the former may receive invaluable guidance in the practical details of professional work and the latter that assistance in routine duties which they frequently need.

2. I think that some such scheme as that outlined above would meet with the approval of the War Office and would meet the needs of the army in India. The greatest difficulty would probably be to maintain the cadre of the permanent army service. This could be done by improving the pay and prospects of the officers of the army branch and by increasing as might be necessary the number of officers of the Royal Army Medical Corps seconded for Indian service.

3. I strongly believe that the scheme as above would attract a good stamp of recruits and meet the demands of professional opinion in England and India. There can be no doubt that very many of the men who are most suited both by professional attainments and personal temperament for civil medical work have been hitherto deterred from entering the Indian Medical Service because of their distaste for military routine duties and their reluctance to give up 5 to 8 years of the most important part of their whole professional career to passing through the military doorway into the civil medical service. I believe that such officers appointed direct for civil employ would be fully prepared to undergo the necessary military training which would render them of use in time of military emergency, and that they would form as has been the case with the medical profession in England during the war an entirely reliable war reserve in case of need.

4. As far as my observation has gone the result of withdrawing European medical officers from charge of civil districts and jails in India has undoubtedly been a certain slackening of efficiency; but that the deterioration in this respect has been far less than might have been expected from the sudden and almost universal withdrawal of superior officers and that actual disaster has been conspicuous by its absence. I think most authorities would admit that the Indian subordinate medical staffs in civil districts and jails have risen in a most creditable manner to the suddenly increased responsibilities which have been thrust upon them.

5. I believe that the scheme as now recommended is the one which will best meet the needs of the civil administration. It would, of course, be seriously affected by the needs occasioned by war on a large scale; but less so than either of the schemes originally suggested which being especially devised from the army point of view would leave the civil organization helpless in case of war. The sacrifice to the civil administration caused by war on a large scale would be of course in proportion to the demands made; but with the more universal (though possibly less complete) military training of the profession in India, whether official or non-official, I think it will be possible to have a considerable nucleus of appointments which in all but the last emergencies would be exempted from military service. Here I would express my agreement with paragraph 30 of scheme C regarding the war reserve of officers in civil employ and a special reserve from European, Anglo-Indian and Indian medical practitioners.

6. The scheme would, I believe, give a sufficient and efficient reserve for military purposes. It would be for the military authorities to see that this essential was secured as the organization develops. The scheme would provide a highly trained reserve for immediate military needs in the Indian army medical service officers seconded in civil employ together with the promoted Indian military assistant surgeons while the whole civil medical service with compulsory training provided in paragraphs 4 and 5 of scheme D would constitute a trained reserve available as need might arise.

I was often surprised at the rapidity with which medical men who had had no previous military training whatever were drafted forward to actual war duties even when the need did not seem specially urgent. The impression has been widely formed that given a good professional grounding and ordinary perceptions and commonsense no very long period was required to make

a man efficient for the special duties belonging to military medical service.

9. As regards recruitment and education of the future officers of the service, whether civil or military, I think that for those admitted direct into the service the arrangement at present in force, should in the main, be permitted to stand. There can be no doubt at all that medical education in the United Kingdom is of a more sound and practical nature, is more directed towards securing efficiency and less towards the mere passing of examinations than is that in Indian medical schools. Added to this there is the immense advantage as regards professional and social ideals and other matters which it is difficult to specify but which Indian officers who have themselves spent years at Home are the first to recognise. I would, therefore, insist on a period of study of at least two to two and a half years in the United Kingdom before entering for the open competition for admission to the services. In connection with this I would strongly support the suggestion made in scheme B (6) and repeated in scheme D that specially selected Indian medical students should be sent Home on Government of India scholarships to enable them to proceed to the United Kingdom with a view to compete at the end of their course for the Indian Medical Service. I agree entirely with the suggestion made in all the schemes that there should be an Indian Army Medical College at some convenient centre which would provide for the training of medical officers of various grades (including reserves) in the subjects connected with military medical duties.

The schemes suggested dealt only with the medical services of the Government of India, but any comprehensive organization for civil medical administration must include provincial as well as Imperial services. Medical men trained in the Indian colleges would be eligible as at present for the provincial civil medical services and from these provincial cadres men who have shewn special professional ability, besides having during their period in the service shewn, from the social point of view, their fitness for promotion to a higher grade, should be so promoted, their period of approved service in the provincial cadre being regarded, in such special cases, as the equivalent to the years of study in the United Kingdom.

12. There can be no doubt that private practice has declined to a considerable extent in the case of officers of the Indian Medical Service in civil employ. The reasons of these are in the main as follows:—

- (a) The considerable increase in the number of European practitioners, including private and general practitioners, medical missionaries (male and female) and railway doctors.
- (b) The large number of Indian medical men trained both in England and in India who are now available for private practice (whether as private practitioners or as assistant surgeons) and the growing confidence of the Indian public in them.

I fear these reasons are unavoidable and that further decline in private practice is probable and indeed inevitable. It is perhaps satisfactory that those posts which do admit of a substantial amount of private practice—the specialist appointments in Presidency cities and the civil surgeoncies in large towns—are also those which demand the highest efficiency in the medical officers holding them.

Special questions.

1. If by the term "purely racial predilection" is to be understood a prejudice founded solely upon colour or race I am quite sure that the demands of European members of the public services for European medical attendance on themselves and their families are based not wholly upon racial predilection. It is equally true that they are not based wholly upon any supposed difference between the professional merits of doctors educated entirely in the United Kingdom and those educated in

11 March 1919.]

Dr. A. LANKESTER.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

India. There is no doubt at all that speaking generally doctors, whether Indian or European, who have had a complete medical education in the United Kingdom are more generally efficient in the exercise of their profession than those trained entirely in India. They have had a better grounding especially in practical work. Their training has been directed less towards the mere passing of examinations and more towards practical efficiency. In a word the difference between Indian and European education generally is also to be found in the case of medical education. It is not, however, by any means merely in professional matters that the period of education spent in the United Kingdom is advantageous. The student who has enjoyed it has had at least the opportunity of assimilating western ideals of professional, social and moral conduct which, whether or no they are necessarily in all respects in themselves superior to eastern ones, are at least more acceptable to European patients.

What is really the main cause of objection is, I believe, rather a difference in point of view especially in regard to sex matters, as between Europeans and some Indians. There are many Europeans who would have no objection to consulting an Indian medical man about themselves or for ordinary ailments of the members of their families, who would nevertheless feel the greatest reluctance to ask them to attend their wives during confinement or for more general illness involving physical examinations. The question of reciprocity comes in in an indefinite but none the less real way. The European patient is often intimate with the inner life of the European doctor's family while that of the Indian medical man is closed to him.

The numerous exceptions to any general rules on this question of racial relationships only emphasize what I have said. I have known capable Indian doctors of refinement and sensitive perceptions with whose families their European patients are on intimate terms and regarding whom the question of race scarcely seems to arise. Such men are becoming more numerous and are doing very much especially in mofussil stations to remove the objections hitherto felt to treatment by Indian doctors. Every effort should, of course, be made in cases where European medical officers are not available to select Indians of this type for appointments which include responsibility for the treatment of Europeans.

To conclude, the difficulty is a very real one but it will tend gradually to decrease; moreover, it is individual rather than purely racial so that it can be minimised by a judicious personal selection by the authorities making appointments.

It is on larger considerations than this that I would base my own personal strong conviction that the proportion of European officers in the Indian Medical Service should be maintained at a high level.

2. In several instances which have come under my own personal observation Europeans have been entirely satisfied with the medical treatment received from Indian assistant surgeons acting in place of European medical officers removed on account of the war. I can recall more than one instance where lady patients have spoken with grateful appreciation of the tact and good feeling shewn by the Indian medical officer in dealing with what was admittedly a somewhat difficult situation. I have had no personal experience of the contrary character but I am sure that during the war Europeans have done their best to minimise and make the best of temporary difficulties of this kind. The fact, however, that the exceptional conditions entailed by the war have been passed through without very acute difficulties does not affect the general position that in a peace organization so far as possible European medical officers should be posted to those appointments which involve professional attendance upon any considerable number of Europeans.

3. I believe that the general standard of efficiency of Indian medical officers of all grades has improved markedly of recent years. It is difficult to speak in general terms of this efficiency, but there has been a

steady levelling up of the standard of training in the Indian medical schools and colleges and this has been reflected in the men who have been trained in them; while the number of Indians who have received their medical training in the United Kingdom has also largely increased.

That there are gradations in efficiency in the various grades all will admit; but one important point for consideration is that no standards of description applicable to pre-war days will be true to-day, owing to the fact that such a very large proportion of Indian medical officers have during the last few years enjoyed as never before one great postgraduate educational advantage, namely, the opportunity of direct personal responsibility for medical work. Numbers of Indian medical officers who have never been obliged, or even permitted to undertake really responsible duties apart from close supervision by senior officers, have suddenly had the whole burden of institutions and the medical care of towns or districts thrust upon them. They have had to do operations and treat serious cases such as they would never have attempted single-handed before. In some cases doubtless this has meant failure, but I believe it is the barest justice to add that a very large proportion of such Indian medical officers have shouldered their burdens bravely and wisely and will be found later on to have become far more capable and efficient as a result. An Indian medical officer of natural keenness and capacity who has for years been working in constant association—both in operations and in medical treatment and in administrative duties—with an experienced and capable senior officer has really been becoming far more capable than either he or any one else realises, until circumstances such as those which have recently occurred force him to work independently.

Medical Stores Department.

1. In His Exalted Highness the Nizam's Dominions all the Government and local fund hospitals and dispensaries are supplied from the stores connected with the medical department. The only other medical institutions are those of medical missions and the railway. These for the most part, I believe, obtain their drug supplies from wholesale firms in Bombay.

2. Formerly all annual indents for the various dispensaries were forwarded to a large firm in England and the separate indents were sent out direct to the hospitals and dispensaries throughout the State. I was convinced that this was an extravagant and wasteful method and have more recently commenced purchasing drugs and requisites in bulk for the medical stores and supplying all our institutions (both as to annual and emergent indents) direct from headquarters. I feel quite sure that this arrangement makes both for economy and efficiency.

In my opinion the larger the bulk of business undertaken by Government medical stores the better from every point of view. It is the large and many-sided business which can command good terms, punctual arrangements, freight economies and the other advantages mentioned in the question. The only possible objection that I can see to the policy of bringing more and more of the drug supply under the direct control of the Government medical department is that of interference with private enterprise. This objection is not, I believe, allowed to weigh greatly in matters of other stores such as those of the army, etc. For the most part the goods would continue to be manufactured by private enterprise and the only difference is that of obtaining them in larger bulk, or, in other words, of dispensing with the services of intermediate firms. I believe it is usually held that the intermediate firm should be made use of so long as it is found to be helpful but not when direct dealing is found to have advantages both in facility and economy.

I may add that as honorary secretary of the medical missionary association of India representing from 200 to 300 medical men engaged in mission hospitals, I have recently had a considerable amount of correspondence

11 March 1919.]

Dr. A. LANKESTER.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

on the subject of the obtaining of supplies for mission hospitals. This has had especial reference to the present difficulties in obtaining goods from the United Kingdom and the expectation that upon demobilisation of war hospitals large supplies of medical requirements might become available. The question, however, also affects the routine supplies of drugs and requisites for such hospitals and when it is remembered that these institutions relieve Government of a very large amount of its responsibility for the medical treatment of people often in otherwise inaccessible areas, it seems a wholly reasonable proposition that they should share the advantage as to economy, etc., which would result from their being permitted to indent regularly upon Government medical stores at Government rates.

There is one special reason in the case of medical stores why a rapid turnover is of advantage. This lies in the fact that not only are many of the goods, e.g., many drugs, rubber goods, electrical apparatus, etc., exceedingly liable to deteriorate on being kept in a warm climate but also that there is a constant change in the methods of treatment so that a drug or a requisite popular at one time may suddenly be displaced by something else. These two facts have led in the past to the accumulation in many medical stores of great supplies of goods which are with difficulty disposed of. The remedy for this would seem to lie in a rapid circulation and increased turnover such as would result from a large expansion of the business undertaken by Government medical stores.

DR. A. LANKESTER, called and examined.

(General Hehir.) It was desirable that Royal Army Medical Corps and Indian Medical Service officers in military employ should be so placed as to give them identically the same duties. They should be used indiscriminately for British and Indian station hospitals.

There were many complaints about the period of 7 or 8 years for which Indian Medical Service officers had to wait before transfer to civil employment. Under the present system the best years of an officer's life, when he was keen on acquiring experience, were wasted in routine military duties. The waiting period for joining the civil should be cut down. He was, however, unable to suggest how this could be effected, as it would depend on military needs.

A combination of schemes C and D, with the modifications suggested in his written statement, would, he thought, meet the civil and military requirements of India.

Teaching in Government medical colleges could certainly not be carried out by the independent Indian medical profession as efficiently as at present by the Indian Medical Service. It might be possible to find an Indian doctor here and there for this work, but speaking generally it must be said that they would not be able to carry on the teaching work efficiently.

If the prospects of the Indian Medical Service were improved, and their grievances removed, it would improve matters considerably, though he doubted if that alone would put things right. It was, however, not impossible to put things right. A separation of the civil from military would go a long way to improve the service. This was one of the things about which he had heard several complaints. Officers who were suitable for civil work were anxious to spend their whole life in that line. He attached great importance to the separation between the civil and military, and to the establishment of an independent civil medical service.

The missionary doctors were not compelled to join the Defence Force. He joined just before taking up his appointment in the Hyderabad State, but had been exempted from actual drill.

It would be possible to make use of lady doctors for soldiers in the army in future wars. They had been used for such duties on a large scale in England, and lately, to a lesser extent, in India.

(Colonel Bhola Nauth.) To divorce the civil from the military medical service would add to the attractions of the former, though it was open to question whether this would not remove some of the attractions of the military. He was decidedly of opinion that a better class of doctors would be forthcoming for the civil if it was separated from the military. The keenest officers were those who entered the service with a view to get into civil.

This separation would, however, undoubtedly have an adverse effect on the military service, and, therefore, it would be necessary to improve the prospects of that service in other directions. There was an almost limitless source of supply in seconding officers from the Royal Army Medical Corps. If at any time the military

cadre got below what was considered necessary, officers could be seconded from the Royal Army Medical Corps.

Research and professorial appointments should be open to the Indian Medical Service.

(Sir T. Nariman.) There would be far less difficulty in obtaining recruits for the civil medical service if it were separated from the military.

(General Hendley.) With reference to the remark said to have been made by him to the effect that work in the jails had deteriorated since the withdrawal of Indian Medical Service officers from civil to military duty, he explained that it had reference to his observations in connection with tuberculosis in the jails. Among Indian officers who were put in charge of the jails there was a tendency to rely too much upon the finding or not finding of tubercle bacilli. They did not attach much importance to general conditions. He had not noticed any deterioration in general efficiency.

Hardly any experienced Indian medical practitioners had volunteered for military duty in the late war. They could not be depended upon to make a war reserve in future.

Quite a large number of missionaries volunteered for active duty in the war. At the very beginning of the war the whole body of medical missionaries placed their services at the disposal of Government through the late Sir Pardey Lukis. In the early days they were not wanted, but some were required to replace officers withdrawn from civil stations. Eventually, quite a large number, especially those who went Home on furlough, joined the forces. He had no authority to say so, but was inclined to think that, in future, missionary societies would be prepared to let their medical officers join the war reserve and receive military training. There might be one or two exceptions but generally speaking there would be no hesitation on their part.

Personally he was of opinion that it would be well if the missionary societies got their drugs by annual indents on the Government Medical Stores Department, but was doubtful what attitude the societies at Home would take. As regards emergent indents it would be an excellent arrangement, and would be of the greatest help.

Most of the subordinate missionary medical staff was recruited from the candidates turned out of the Agra Medical School and the Medical School for Women at Ludhiana. There are one or two schools in south India also which had a course of instruction for three or four years. The education imparted in these institutions was sufficient for the work that these subordinates were called upon to undertake. They were put in charge of small dispensaries, and if doctors with higher qualifications had to be sought for the result would be that thousands of people in the villages would go unattended. The arrangement was not the best one, and was merely a compromise. On the whole it was good to have men of this stamp. They were not fully qualified, but the societies were trying to get qualified persons from the medical schools. The question was simply one of cutting one's coat according to cloth. Besides, it was difficult to get a sufficient num-

11 March 1919.]

Dr. A. LANKESTER.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

ber of Christians, as they were generally poor and could not afford to undergo a long course of studies.

The number of Indians to be recruited for the Indian Medical Service should only be limited by making the test, that is the entrance examination at Home, severer. There should be only one entrance examination and that in London. He was not in favour of an examination in India. A period of about two or three years' study in England was essential, before an Indian competed for the examination, to acquaint him with social and professional ideals.

(Mr. Hignell.) No special provision should be made for the recruitment of Indians, and only the best men should be selected. If it were decided to recruit a certain proportion of Indians, he would prefer, that this object should be attained by reserving for Indians a certain proportion of the vacancies at each examination held in England, rather than that they should be admitted by examination in India. He laid stress upon the training in England, which was more important than the mere passing of an examination. The life in England and the opportunities of mixing with people there were of the greatest importance.

(General Giffard.) He did not favour the idea that Indians should be selected in preference to better men, in case a proportion was fixed. It would be far better to select the best men. If Europeans stood better in the test they should be selected in preference to Indians. He would not mind having an examination in India so long as there was a condition laid down that the students should have training in England for a certain period. The trip to England was of the greatest benefit, and there was something in the education in England which could not be had in India. The service would go down if recruitment were simply by an examination in India.

The best and the strongest of the attractions of the Indian Medical Service had been the prospect of civil work. The keenest and best officers had spent most of their time and energy in civil.

If three services, namely, the British army service, the Indian army service, and the Indian civil medical service, were started it would be possible to make the Indian army service attractive and to get sufficient recruits, and in case there was some deficiency it could be made up by seconding officers from the Royal Army Medical Corps from time to time.

Military medical officers would have better chances of remaining professionally efficient, even if they spent their whole life in that line, if they served both with British and Indian troops. It was desirable that military medical officers should be seconded for civil work. The civil ought not to be a mere appendage to the army.

In reply to the question as to what would be the difference between a service which was purely military but was used for civil duties, and a purely civil service which was called upon to do military duty, he remarked that any officer would turn out the best work in the line to which he considered he belonged. In the second case the officer's military duties would be subsidiary, and he would regard them as an ordinary layman would regard his compulsory service.

He agreed to the reversion of a civil officer to military duty for six months every fifth year, but this sort of reversion would be in the interests of his country, and would not be a serious interruption to his life's work and interest.

If the amalgamation of the Royal Army Medical Corps and the military side of the Indian Medical Service were not carried out, he would not propose a division of the civil and military.

(General Hehir.) It would not be a good thing to let the service continue as at present.

(Mr. Hignell.) There must be reversions to the military for short periods.

(General Cree.) Even though he had suggested a purely military and a purely civil service he was opposed to scheme A, which proposed to do away with the Indian Medical Service as a military organization. All Indian Medical Service officers would not like to go to the civil and there would be many who would like an all-India service on the military side. When the Indian and European armies were amalgamated for medical purposes it would be a great advantage to have a medical officer who had his whole service in India. An officer of the Royal Army Medical Corps, who had come out for five years was not fit for such work as he would be wanting in knowledge of Indian regimental work. He had rejected scheme A as it seemed to him to shut out the Indian Medical Service from the military side altogether.

DR. M. KESAVA PAI, M.D. & C.M., Acting Assistant Director, The King Institute, Guindy.

Written statement.

General.

None of the schemes set forth in the annexures to the letter seem to me to do justice to the medical graduates of this country, the qualifications of most of whom are registrable in the United Kingdom and whose capacity to hold the higher medical appointments and discharge the administrative duties of district medical officers has been fully demonstrated during the great war which has just come to a close. The free and prompt response to the call of the Empire made by the civil assistant surgeons and private medical practitioners of the country in taking up temporary commissions and the satisfactory manner they have discharged their military medical duties bear ample evidence to the fact that, given the opportunities, there is sufficient talent in the country which is adequate not only to carry on the greater part of the duties of the higher civil appointments but to meet the exigencies of war at comparatively short notice.

In any scheme to reorganize the medical services, the Indian medical graduate, therefore, deserves every recognition from the Government. The annual administration reports of the medical departments of the various provinces of India have borne full testimony to the fact that the local medical graduates of the present day are sufficiently equipped to keep up the prestige of the department and discharge the functions of the executive medical appointments with credit to themselves and to their country.

Before trying to answer the various questions in the annexures, I beg to submit, for the abovementioned reasons, a separate scheme in brief for the reorganization of the Indian medical services.

A.—The military medical service.

This can continue to be manned as at present by (a) officers of the Royal Army Medical Corps, (b) by Indian Medical Service officers selected by an open competition which should be held simultaneously in England and in India. Such of the officers as are selected by the examination in India should be made to undergo the necessary military training in England along with the candidates recruited in England.

The subordinate personnel to continue as at present, but the position and status of the Indian military sub-assistant surgeon to be materially improved. Military assistant surgeons of merit with British registrable qualifications should be granted commissions.

B.—The civil medical service.

This service should consist of (a) first class officers made up of (1) military medical officers from class A to the extent of 50 per cent., (2) officers promoted from amongst civil assistant surgeons of over 14 years' service in the case of medical graduates and 20 years' service in the case of promoted sub-assistant surgeons. These constitute the remaining 50 per cent.

11 March 1919.]

Dr. M. KESAVA PAI.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

(b) Second class officers to be constituted by civil assistant surgeons recruited by competition from medical graduates and by selection from the sub-assistant surgeons of proved merit and ability of over 14 years' service—10 per cent. of the appointments in this class can be reserved for such promoted sub-assistant surgeons.

(c) *Sub-assistant surgeons.*—The status of these officers requires to be improved. The ideal to be kept in view is so to improve the present course of study of the L. M. S. as to bring it on a par with the diplomas granted in England, so that in course of time the licentiate could sit with the graduates for the competitive examinations for appointments in all the grades of service.

All officers of the civil medical service (a), (b) and (c) should constitute a war reserve and should be given initial and periodical military training in India. When drafted into the military for training or in the event of war officers of class (a), (2) should be given military rank according to their periods of service and officers of class (b) a temporary commission of the lowest grade.

C.—Special appointments.

These should include the professional appointments of medical colleges coupled wherever necessary with corresponding clinical charges in the State hospitals, chemists, bacteriologists, ophthalmologists, etc., to be recruited from the medical profession in England and in India, both service and non-service men being eligible. Efficiency should be the aim in selection and not economy. These appointments should be independent of any war reserve.

Answers to questions for witnesses.

1. The answer to this question is embodied in the scheme I have outlined above.

2. The scheme I have commended ought to meet with the approval of the War Office and meet all the needs of the army in India.

3. The scheme will attract good recruits and satisfy the demands of the medical profession in England and in India.

4. I am not aware of any lasting untoward effect resulting from such a withdrawal.

5. The scheme outlined by me will fully meet the requirements of the country both during war and in times of peace.

6. The same scheme will give quite a satisfactory military reserve.

7. A previous military training is always desirable and the reserve must be present in India without unduly burdening the resources of the country. Hence the importance of giving the civil medical service a routine military training.

DR. M. KESAVA PAI, called and examined.

(Lieutenant-Colonel Bhola Nauth.) He was in favour of a separate civil and military service. He would recruit for the civil from the military as was done at present. Assistant surgeons should also be promoted to commissioned rank after 14 years' service, and should be given a European training.

With reference to the question of providing European doctors to attend on European officers and their families, he considered that there was a certain amount of racial feeling amongst Europeans. They usually prefer to be attended by European doctors. Indians also have a certain amount of racial feeling but in their case it is not so marked. He was of opinion that man for

9. The answer to this question is contained in my scheme.

10. A course of twelve months of study must be made compulsory to all medical officers.

11. Medical officers holding certain special appointments may be given special allowances in lieu of private practice and given facilities for research. Whole-time research workers may from time to time be selected for special work.

12. The general class of Indian Medical Service officers in civil employ may not be getting such a lucrative practice now as some years ago on account of a better class of local medical graduates in Government service and a larger number of efficient private medical practitioners.

The practice of Indian Medical Service officers holding special appointments at the Presidency has not suffered.

Answers to special questions.

1. Racial predilection plays an undoubted part in the demand of Europeans for European medical attendance. Cases are not infrequent, however, when Indian medical men of worth have been preferred by Europeans though a European doctor was available on the spot. The question of European or Indian education does weigh also in the selection.

2. The efficiency of Indian medical officers of all grades is certainly on the side of steady improvement.

Answers to questions for civil assistant surgeons.

1. Civil assistant surgeons will be prepared to do military duties on the conditions laid down in my proposed scheme.

2. Pension rules require modification. Medical men ought to be allowed to retire on full pension after 25 years of service, since they work without holidays and vacations.

4. The disabilities and their remedy are indicated in my scheme outlined above.

5. With the present prospects of the civil assistant surgeons it is needless to say that the best men select other departments and professions. A much better type of men will be attracted by a scheme similar to the one I have proposed.

6. No.

7. The civil assistant surgeon is, as a rule, more popular than the military assistant surgeon of the same capacity. Throwing open civil appointments to a larger number of military assistant surgeons will no doubt cause dissatisfaction amongst civil assistant surgeons.

8. If the scheme proposed by me be adopted, no dissatisfaction need be felt or recruitment affected adversely.

man an European officer was better than an Indian at the present time.

(General Giffard.) He advocated the gradual abolition of the sub-assistant surgeon class. Those who could not obtain the higher appointments by competition would take the lower and so the work of the sub-assistant surgeon would be carried on. If a man failed he would be kept below a certain grade. He did not like the sub-assistant surgeon shut up in a watertight compartment. There should be two services—the superior and the subordinate. Those who could not obtain admission into the superior would have to remain in the subordinate.

RAO SAHIB U. RAMA RAO, Madras Branch, All-India Sub-Assistant Surgeons' Association.

Written statement.

Questions for witnesses.

Q. 1.—What defects have you noticed in the organization of the Royal Army Medical Corps and the Indian Medical Service in India? Does any of the attached

schemes which are suggested with a view to remedying existing defects commend itself to you, and if so, which and why?

11 March 1919.]

Rao Sahib U. RAMA RAO.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

A.—None of the schemes attached, commends itself to me in its entirety. The scheme that I suggest is as follows:—

- (a) For the purpose of the unified military medical service, the Royal Army Medical Corps and the Indian Medical Service may be amalgamated, if the military experts approve of it.
- (b) As for the civil medical service, I am opposed to recruiting men for it in the United Kingdom. It should be recruited in India by competitive examinations open to all medical graduates of Indian Universities, to holders of diplomas of the medical schools and to men with English qualifications.
- (c) As for the subordinate personnel it should consist of only one class, that is, military assistant surgeons, to be recruited in India by competition, open to all Indians and Anglo-Indians. This service should not be reserved for Anglo-Indians alone.
- (d) For the purpose of the military reserve the men recruited in the manner indicated in subparagraph (b) above, should be held liable for military duty when required and accordingly trained in the military medical colleges.
- (e) If it is considered that these should have social training in England, they may be sent there at the expense of the State.
- (f) Private practitioners may be induced to take a part-time share in the work which is now wholly in the hands of the Government services by appointing them as honorary physicians and surgeons in big and busy hospitals. By this arrangement a large number of men in service may in times of war be readily drafted for military duty, the work of the hospitals being managed by the private practitioners.

Q. 4.—What has been the result of withdrawing European medical officers from charge of troops, civil districts and jails in India?

A.—Nothing abnormal has happened. Everything has gone on as if no change had occurred.

Q. 5.—Will the scheme which you recommend meet the needs of the civil administration in India? To what extent would it be affected by needs occasioned by war on a large scale?

A.—Yes. I don't think it would be affected to any appreciable extent.

Q. 6.—Would the scheme which you recommend give a sufficient and efficient reserve for military purposes? If not, how would you supplement it?

A.—Yes.

Q. 7.—Do you consider that it is necessary to have a medical service reserve for war previously trained in military work, and must such reserve be always actually present in India?

A. Not necessary. If all the civil medical men in the service of Government and private practitioners appointed as honorary physicians and surgeons, are given the necessary military training there will be no need for maintaining a medical service reserve for war.

Q. 9.—What system of recruitment and education do you consider as desirable for medical officers in connection with the scheme which you prefer?

A.—Training in Indian schools and colleges and recruitment to the higher grades by competitive examinations and selection of deserving men of good service in the subordinate grades.

Q. 10.—Have you any suggestion to make as to the grant of special leave for study or as to prescribing periods of study?

A.—One year's study leave is absolutely necessary.

Q. 12.—How far has private practice declined in the case of officers of the Indian Medical Service in civil employ? If it has declined what are the reasons?

A.—I think their practice has not declined. Those who had good practice have it even now. It is the position that brings practice and not the person alone. For

instance, the First Surgeon, the First Physician, the Ophthalmic Surgeon and the Superintendent of the Maternity, whoever they may be, can have and always have roaring practice.

Questions for civil and military sub-assistant surgeons.

Q. 1.—Are you satisfied with your position as an Indian warrant officer? If not, give reasons.

A.—Certainly not. It is an anomalous rank in the Indian army, because we in the Indian station hospitals do not have the privilege or the status of the British warrant officer of the British hospital. We are neither commissioned nor non-commissioned officers. As warrant officers we have some duties to perform and responsibilities to bear in the Indian station hospitals, such as maintaining discipline, etc., but as we have no rank we find it difficult to enforce discipline and discharge our duties satisfactorily.

As military sub-assistant surgeons are directly under the Indian Medical Service officers we are mainly responsible for the work, discipline, etc., of the Indian station hospitals. This we cannot satisfactorily perform unless we have a status in the army. We, therefore, think it imperative that our class of men should be given commissions to start with so as to enable them to discharge their duties efficiently.

Q. 2.—Do you consider that study periods will be important to your branch of the service, and, if so, should they be taken in (a) existing medical colleges, and (b) a proposed new military medical college in India?

A.—Yes. They may be taken in the proposed military medical college for specialising in matters military and in the existing medical colleges for training in special subjects.

Q. 3.—Should the local governments decide to throw open civil appointments to a large number of military sub-assistant surgeons, do you think such appointments will be popular and sought after?

A.—Yes. They will be popular and eagerly sought after by the military sub-assistant surgeons.

Q. 4.—Do you consider that military and civil sub-assistant surgeon pupils should have a higher preliminary school or university qualification than they do at present?

A.—There must be a uniform standard of general education (throughout India) for admission to the medical schools. The matriculation or the secondary school-leaving certificate course modified, if necessary, to meet the requirements of the General Medical Council shall be the minimum standard of qualification for admission, preference being given to candidates whose optional subject is science.

Q. 5.—What will be the effect on recruiting for the military sub-assistant surgeons and civil sub-assistant surgeons classes of demanding a security deposit of money before commencing training, which deposit would lapse to Government if the sub-assistant surgeons fail to complete the necessary five years' service.

A.—It will be very unpopular and will greatly hamper recruiting.

Q. 6.—Is the bond now signed satisfactory, under which civil sub-assistant surgeons may be drafted to military employ during or after five years' civil service?

A. The present bond is operative only for five years.

Q. 7.—Is service with the army under present conditions satisfactory to civil sub-assistant surgeons, and if not, what remedies do you suggest?

A.—Very unsatisfactory. When on military duty the civil sub-assistant surgeons must be given commissions, styled assistant surgeons and given the same facilities, pay, pension, separation allowance, family pension, etc., as in the case of military assistant surgeons.

Q. 8.—If Government propose that all civil sub-assistant surgeons should undergo a course of military training, will this be popular in your department and will it affect recruiting?

A.—It will not be unpopular and it is not likely to affect recruiting, provided the service is made sufficiently attractive.

11 March 1919.]

Rao Sahib U. RAMA RAO.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

Q. 9.—Are you satisfied with your present scale of pensions?

A.—No. So far as civil sub-assistant surgeons are concerned retirement on full pension after 25 years should be optional and after 20 years' service should be on medical certificate.

As regards military sub-assistant surgeons their case should be dealt with in the same way as military assistant surgeons or Indian commissioned officers. When a civil sub-assistant surgeon dies from the effects of injuries received or diseases acquired in the performance of his legitimate professional duties his family should be allowed a commuted pension or bonus or something similar to it.

Q. 10.—Do you consider that there should be a scheme of pensions for widows and orphans of both military and civil sub-assistant surgeons? If so, would the sub-assistant surgeon be prepared to contribute?

A.—Yes. He would contribute. The present scale of family pension in the case of military sub-assistant surgeons is very poor. Almost all the other ranks of the army combatants and non-combatants get half their rank pay if killed in action and a little less if they die in active service. The sub-assistant surgeon is the only exception to this rule.

The following comparative statement will show the disability in the case of the sub-assistant surgeon:—

Ranks of the army.			
Rank	Pay. Rs.	Pension. Rs.	
Subadar	100—120	50—40	
Jamadar	60	25—20	
Non-commissioned officer	18	8—7	
Naik	15	6—5	
Sepoy	12	5—4	

Sub-assistant surgeon.			
Pay. Rs.	Grade.	Pension. Rs.	
145	Subadar	50—40	
125	Jamadar	25—20	
110	First, second and third classes	15—12	
95			
75			
60			

Even a follower getting Rs. 50 is allowed a family pension of Rs. 25 or Rs. 20, but a sub-assistant surgeon getting from Rs. 60 to Rs. 110 is allowed only Rs. 15 or Rs. 12.

There seems to be a proposal to open free schools for the children of Indian officers and ranks. All these concessions should be extended to the children of sub-assistant surgeons as well.

Pensioned Indian officers and ranks are entitled to their pensions and grade pay if re-employed, but a sub-assistant surgeon is allowed only his grade pay and no pension. This injustice must be remedied.

The benefit of Postal Life Insurance is not open to military sub-assistant surgeons; it should be extended to them also.

Q. 11.—Are there any other specific disabilities in your service which you desire to bring to the notice of the Committee?

A.—Every military sub-assistant surgeon should on appointment be given an Indian commission or British warrant rank.

When attached to station hospital he must be placed on a footing of equality with the assistant surgeon in the matter of position, pay, pension, bonus, separation allowance, field batta and charge and travelling allowances, etc.

One of the greatest disabilities of a sub-assistant surgeon is that he has absolutely no scope for rising to higher ranks of the service, whatever his capacity. He starts as a sub-assistant surgeon and ends as a sub-assistant surgeon—a disadvantage which exists in no other department of Government service.

The L. M. P. course should be raised to five years and so modified as to make it acceptable by the Royal College of Physicians and Surgeons in England.

Licensed medical practitioners of the proposed five years' course who have served for one year as house surgeon and physician must be allowed to compete for the assistant surgeons' cadre.

Sub-assistant surgeons and practitioners of ten years' standing and above of the present four-years' course must also be allowed to compete with those possessing university degrees.

One-third of the vacancies in the cadre of assistant surgeons must be filled up by selection from among sub-assistant surgeons who have put in fifteen years' approved service or more.

The General Medical Council should be moved to recognize our proposed five years' course.

The instructors in our medical schools should be men who have specialized in the subjects which they teach.

The name of the diploma L. M. P. should be altered to L. M. S.

The numbers assigned to each sub-assistant surgeon should be done away with.

The pay of sub-assistant surgeons should be fixed at Rs. 100 rising to Rs. 300 by annual increments of Rs. 10.

The period of privilege leave should be increased to six weeks for every 10½ months of active service as sub-assistant surgeons are denied the benefit of Sundays and other public holidays.

In the case of military sub-assistant surgeons the scale of pay may be the same as civil sub-assistant surgeons plus one additional grade of Rs. 350 for a selected few on the rank of honorary captain and lieutenant.

The designation "sub-assistant surgeon" should be done away with and in its place should be substituted "Medical officer" such and such grade.

Q. 12.—Have you any suggestions to make regarding the present method of recruiting for your service?

A.—Any qualification inferior to the present L. M. P. or the proposed L. M. S. of five years' course should not be accepted.

The system of stipends should be abolished.

There should not be two branches of service, military assistant surgeon and military sub-assistant surgeon, but only one combined service thrown open to all Indians, including Anglo-Indians.

Q. 13.—As warrant officer have you any difficulty at present in connection with the maintenance of discipline in regimental or Indian station hospitals?

A.—Yes; please *vide* answer to question 1.

Q. 14.—What would be the effect on the civil sub-assistant surgeon service of the wearing of uniform and other military privileges and disabilities that would affect sub-assistant surgeons if they were brought under the Army Act when serving in military employ?

A.—When civil sub-assistant surgeons who have no idea of the army and its stringent regulations are suddenly drafted to the military and brought under the Army Act they generally find it hard to adjust themselves to their new position and become an easy prey to the Army Act. They, therefore, dread military service. To avoid this difficulty and make military service popular among civil sub-assistant surgeons the best course will be to give them some preliminary training in military discipline and other details of their new duties so that they may become accustomed to the new life and its demands.

Q. 15.—What would be the effect on the civil sub-assistant surgeon service and on recruitment for that service of making field service in time of war one of the conditions before employment in the civil medical service?

A.—So long as present conditions continue recruitment cannot be popular. Given rank and attractive pay recruitment will be satisfactory.

In conclusion, I may state that sub-assistant surgeons as a class are willing workers. If some of them have failed to respond to the call for military duty it is because they have neither status nor adequate remuneration. In proof of it I may state that when sub-assistant surgeons were offered the posts of assistant surgeon in the Hospital Ship, Madras, there were as many as 150 applications for the four posts offered. In the

11 March 1919.]

Rao Sahib U. RAMA RAO.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

present war every medical man other than the sub-assistant surgeon was benefitted in some way or other. The educational history of the sub-assistant surgeon will

show as if it was always a makeshift emergency corps for famine, war and epidemics. We look to this Committee for redress.

RAO SAHIB U. RAMA RAO, called and examined.

(General Giffard.) From the city of Madras six Indian private medical practitioners volunteered to serve in the army. This was not much, but the failure of volunteering in the past was due more to the fact that they had no idea of the kind of work which they would be asked to do. Some of them were under the impression that they would be sent away from India. As regards the future, he had not the least doubt that these medical men would volunteer in greater numbers to serve in the army. They should be given some military training. Both during their course of training and afterwards, they should be paid something in the shape of retaining fees.

Private practitioners would not object to leave their practice to undergo military training if it was for a reasonable time. This training would enable them to have an idea as to what they would be asked to do if and when they volunteered. Afterwards there would be no difficulty in getting the required number of doctors.

The civil work of a country was bound to suffer if its medical services were organised largely on a military basis. If military officers, who were employed in civil work for some years and who had gained a certain amount of experience in the country, were taken away for military duty, their experience would be lost to the country.

The ambulance corps which he had trained and sent out had done very useful service in connection with the war and it would be available at any time hereafter for any place with private medical practitioners as officers.

The ambulance men came of very respectable families and did not require any fees; but these men should not be taken away for more than six months at a stretch. On the other hand, the medical practitioners would require to be paid something in the shape of retaining fees.

(General Hehir.) The ambulance men were composed mostly of students and to a small extent of clerks employed in business houses. On the whole the witness had trained about 3,000 men since the outbreak of war.

On other occasions like festivities, fire, etc., the ambulance corps had done a very useful service in Madras.

Private practitioners would be very willing to undergo military training. During their absence, they could easily entrust their work either to their assistants, of whom the witness had two, or to other medical practitioners. In former days there might have been some difficulty as there were only very few men available, but it was not so at present.

A period of six months or two periods of three months each would be ample for their military training.

No. 1328, First Class SUB-ASSISTANT SURGEON P. A. CHENGALVARAYAN, I.M.D., Secunderabad.

Written statement, being an account of the proceedings of a meeting of the Secunderabad branch of the All-India Sub-Assistant Surgeons' Association, held at Secunderabad, on the 5th March 1919.

1. Qualification for admission into the medical schools.—School final students who have science as their optional subject should be selected after a competitive examination.

2. Course of instruction.—To last for five years and to include both theory and practice.

3. Hostel accommodation.—There should be free hostel accommodation for the stipendiary students.

4. Amount of stipends—

	Rs.
For the first and second years . . .	25
For the third year	30
For the fourth and the final years . . .	35

5. Reorganization of the medical schools.—The lecturers should be Indian Medical Service officers or assistant surgeons of not less than ten years' service. The present system of posting fresh and raw men from the college for clinical subjects should be stopped. Every medical school should have hostel accommodation.

6. Amalgamation of the civil and military.—The civil and military class of sub-assistant surgeons should not be amalgamated. Civil sub-assistant surgeons within the bondage period should serve in the military for two years (within India) and spend the rest of the five years in the jail or agency service. Military sub-assistant surgeons after completing a certain number of years in the military should be allowed to go to civil and a certain percentage of posts in the civil should be reserved for them.

7. Status of sub-assistant surgeons.—Civil sub-assistant surgeons should be gazetted officers and the military sub-assistant surgeons should be commissioned officers. The "air tight" compartment of the sub-assistant surgeons should be opened out. Sub-assistant surgeons, civil and military, private and Government servants should after passing their examination and after three years' practice or service, be allowed to sit for the higher final examination without any collegiate

course. The sub-assistant surgeons' course should be recognised in the United Kingdom and should be a registrable qualification in the United Kingdom.

The Government of India should be requested to influence the various universities of India to take such sub-assistant surgeons of three years' standing service to sit for the assistant surgeonship competitive examination and to select deserving men and take them in their service as assistant surgeons if the candidates are willing.

After 15 years of standing and approved service, the sub-assistant surgeons should be made pucca assistant surgeons.

8. Pay and promotion of sub-assistant surgeons.—The pay and promotion of the sub-assistant surgeons should be so proportioned like that of the assistant surgeons.

The pay of the civil sub-assistant surgeons should be three-fourths of the assistant surgeons (civil) and that for the military sub-assistant surgeons should be three-fourths of the pay of the assistant surgeons (military).

The promotion should be also proportioned as for the assistant surgeons.

9. Allowances for the sub-assistant surgeons.—The allowances of the civil sub-assistant surgeons are very meagre. The following proposals are made :—

- Charge allowance of a dispensary or hospital should be 30 per cent. of the pay of the sub-assistant surgeon.
- For agency, jail, famine, cholera and plague duties, etc., 50 per cent. of their pay is proposed.

For military sub-assistant surgeons the allowances should be one-half of the assistant surgeons.

10. Travelling allowance.—Civil sub-assistant surgeons should be made pucca second class officers even in places where the inter-class exists. Military sub-assistant surgeons should be allowed to travel on Form "E."

11 March 1919.]

Sub-Assistant Surgeon P. A. CHENGALVARAYAN.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

Daily allowance—

For the civil Re. 1 per day.
For the military Rs. 2 per day.

Road journey—

For the civil As. 4 per mile.
For the military As. 8 per mile for the individual and As. 4 for the family and As. 2 for the children.

Civil sub-assistant surgeons should be appointed as assistant instructors in the medical schools and their allowance should be 100 per cent. of their pay.

Field allowances for the military sub-assistant surgeons.—The field allowances to the military sub-assistant surgeons should be 50 per cent. of their pay while on foreign service which should be increased according to the locality, in addition to their separation allowance while on field service which should be fixed at three-fourths of the separation allowance of the military assistant surgeons.

Quarters.—Compensation for quarters should be fixed as follows :—

	Rs.	
Senior grade	25 per mensem	} plus 50 per cent. Pre-sidency allowance.
1st and 2nd class	20 per mensem	
3rd class	15 per mensem	

The present quarters are inadequate and too small. There should be at least two more rooms. Furniture should be provided in the quarters as is done for the military assistant surgeons. Government should provide quarters free for the sub-assistant surgeons and compensation is only secondary.

Suitable arrangements should be made to provide water supply for every house separately.

Pension.—The full service pension for the military sub-assistant surgeons should be 21 years, and that for the civil should be 25 years.

Invalid pension for the military sub-assistant surgeon should be 18 years and that for the civil should be 20 years.

Rate of pension.—For the military the rate will be as follows :—

Retiring pension after completing 21 years' service should be three-fourths of the pay for the last three years.

Invalid pension should be three-fourths of the pay for the last three years.

From the 10th to the 18th year of service if invalidated by a medical board, he must get 2/60th for each completed year of service of the average pay of the last three years.

Under ten years of service, if invalidated by a medical board, he should at least get Rs. 15 per mensem as pension. There should be adequate remuneration to the sub-assistant surgeon or his next-of-kin for the disabilities or casualties incurred while on duty. This should be in addition to the family pension.

Senior grade—

Higher rate 50 per cent. of pay.
Lower rate 40 per cent. of pay.
1st, 2nd and 3rd classes—
Higher rate 40 per cent. of pay.
Lower rate 30 per cent. of pay.

Civil sub-assistant surgeons.—Full pension after 25 years of service, 50 per cent. of pay (for the last three years).

Invalid pension after 20 years of service, 50 per cent. of pay (for the last three years).

There should be adequate remuneration to the family of the sub-assistant surgeon or to the sub-assistant surgeon for disability or casualty incurred by him while on duty.

Family pension to the civil sub-assistant surgeons.—Same as the military sub-assistant surgeons.

Free passage (by land and sea) while a sub-assistant surgeon is going on 60 days' leave or privilege leave for himself and his family.

Free passage (by sea and land) while the sub-assistant surgeon is going on leave on reduced pay both for himself and his family.

Sub-charge allowances for sub-assistant surgeons in sub-charge of section hospitals, detention or infection rooms, train duties, camp duties, etc.

Decorations.—The military sub-assistant surgeons should be given the commission of "Jemadar." After five years' service they should be made as "Subadars." After ten years' service they should be made "Lieutenants" and after 15 years' service they should be made "Captain."

SUB-ASSISTANT SURGEON CHENGALVARAYAN, called and examined.

(General Giffard.) He suggested that sub-assistant surgeons who had done a five years' course of study and who had obtained a school final certificate should be eligible for a degree. This should apply to those who had obtained 50 per cent. of marks. Sub-assistant surgeons who had undergone a five-years' course would not be satisfied with the present rate of pay. They should start on an initial pay of Rs. 80 per month.

Military students were not granted compensation in lieu of hostel accommodation. At present an allowance of Rs. 4 a year was granted for hostel accommodation, but this was quite inadequate. This allowance should be raised to Rs. 6 a year.

The amount of stipend proposed in his written statement was based on the assumption that no hutting or other allowance would be given.

The witness asked that the present system of appointing inexperienced men from the college for teaching clinical subjects should be stopped. Lecturers should either be Indian Medical Service officers or assistant surgeons of not less than 10 years' standing.

It was the opinion of the sub-assistant surgeons, whose views he represented, that the two classes of civil and military sub-assistant surgeons should not be

amalgamated. Personally, he was in favour of amalgamation.

It was the general opinion of sub-assistant surgeons that the military sub-assistant surgeon should, after completing a certain number of years in military, be allowed to go to civil, and for this purpose a certain percentage of posts should be reserved for them.

After completing three years' service, a sub-assistant surgeon, who had started with university qualifications sufficient to take a degree, should be allowed to count his course in school as equal to the course in college, and to appear for an university examination.

He advocated the grant of family pensions to civil sub-assistant surgeons. They would have no objection to contributing towards a family pension fund. Men drawing a salary of Rs. 100 a month should be asked to contribute Rs. 10 or Rs. 15 a month and those drawing Rs. 60, Rs. 5 a month. The least a widow should get, should be Rs. 25 a month, and each child Rs. 5.

With the advent of the Indian station hospital system all sub-charge allowances had been done away with. He suggested that these allowances should be granted again.

12 March 1919.]

Major F. F. ELWES.

*(The schemes and questions referred to by witnesses are contained in Volume III.)***At Madras, Wednesday, 12th March 1919.****PRESENT:**S. R. HIGNELL, Esq., C.I.E., I.C.S. (*Presiding*).

MAJOR-GENERAL G. CREE, C.B., C.M.G., A.M.S.

MAJOR-GENERAL P. HEHIR, C.B., C.M.G., C.I.E., I.M.S.

MAJOR-GENERAL H. HENDLEY, K.H.S., I.M.S.

THE HON'BLE MAJOR-GENERAL G. G. GIFFARD, C.S.I., I.M.S.

LIEUTENANT-COLONEL A. SHAIRP, C.M.G., Indian Army.

MAJOR M. T. CRAMER-ROBERTS, D.S.O., Indian Army.

and, as co-opted members SIR T. NARIMAN, KT., and LIEUTENANT-COLONEL BHOLA NAUTH, C.I.E., I.M.S.

MAJOR A. A. MCNEIGHT, I.M.S. (*Secretary*).

MAJOR F. F. ELWES, C.I.E., M.D., I.M.S., First Physician, General Hospital, Madras.

*Written statement.**Questions for witnesses.*

I. *Defects in the Royal Army Medical Corps.*—The system in existence during peace time does not provide sufficient opportunities for a medical man to improve or even maintain his professional knowledge. The system in fact leads to an almost inevitable deterioration in professional knowledge.

Defects in the Indian Medical Service.—Officers in military employ labour under the same disadvantages as their colleagues in the Royal Army Medical Corps with regard to the maintenance and improvement of professional knowledge. Another serious defect in the Indian Medical Service is the totally inadequate reserve of officers which leads to extreme difficulty in obtaining furlough when it is due, or even when it is long overdue. This difficulty which existed before the present war commenced, will be enormously enhanced after the war, unless adequate steps are taken to remedy this defect and supply a sufficient reserve of officers. The inability to obtain furlough to Europe leads to a deterioration in both physical and mental energy and precludes the possibility of acquainting oneself with the latest European advances in professional knowledge and methods.

The existence of two separate services—the Royal Army Medical Corps and Indian Medical Service—leads to jealousy and friction.

None of the attached schemes commends itself as a whole to me, but I am of opinion that either B or C scheme if modified suitably would be satisfactory (*vide* appendix I and appendix II).

II. I have no indication of what the War Office desires, but B or C scheme suitably modified would tend to increase the efficiency of the service, and will meet the needs of the army in India and should, therefore, presumably meet with the approval of the War Office. The cost of a medical service as proposed will, however, probably be greater than at present, but efficiency should be considered before expense.

III. B or C scheme, if suitably modified and provision made for study periods and for adequate leave in practice and not on paper only, should attract a good stamp of man and meet the demands of professional opinion in England and India.

IV. The withdrawal of European medical officers from civil stations in the Madras Presidency has caused an influx of European patients particularly women to the Presidency town for the express purpose of being attended by European medical officers.

V. Scheme B or C suitably modified will meet the needs of the civil administration in India. War on a large scale would withdraw "war reserve" officers

from civil employ, but those holding "residuary appointments" would still remain in civil. The appointments of the "war reserve" officers reverting to military could be filled for the duration of the war by promoted subordinate medical officers, by private practitioners and by duplicating appointments.

VI. Yes, a sufficient and efficient war reserve for military purposes would be obtained.

VII. Yes, I consider it necessary to have a medical service for war previously trained in military work and a large proportion of such reserve should always be present in India.

VIII. The Indian Medical Service reserve (civil side) has undoubtedly been of great value in the war both directly by supplying experienced medical men all of whom had had some military training immediately on the outbreak of war, and indirectly by supplying a continuous stream of medical officers for temporary commissions and of military assistant surgeons from the medical schools in India, all of whom have been trained by officers of the Indian Medical Service in civil employ.

IX. I recommend recruitment by open competition in England, but Europeans, Anglo-Indians or Indians domiciled in India whether or not they possess a British registrable qualification, should, however, take a course of at least one year in England preferably before passing the entrance examination into the service.

If, however, it is considered necessary to provide greater facilities for Indians to enter the proposed Indian Medical Corps, then I would recommend that a certain definite proportion, say 20 per cent. to 25 per cent. commissions be reserved for Indians selected in India by nomination and competitive examination. Indians so selected must, however, proceed to England to go through a course of at least one year in England. The position of these candidates should be determined by the result of the final entrance examination into the service after undergoing a course at Millbank.

Seconding from the Royal Army Medical Corps into the Indian Medical Corps should only be temporary and should exist only until the Indian service attains its full complement. If, however, it be decided to retain the seconding of Royal Army Medical Corps officers into the Indian service, then the entrance examinations for the Royal Army Medical Corps and Indian Medical Corps must be identical and Royal Army Medical Corps officers when seconded to the Indian Medical Corps must take their place in it according to their position on the list at the entrance examination.

X. "Study periods" should be compulsory, but these periods should not be counted as leave. There should be at least two study periods, the first period to be

12 March 1919.]

Major F. F. ELWES.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

taken between five and ten years' service, and not to be less than six months' duration. The second study period or periods to be taken between ten and twenty years' service. Special departments may require special regulations regarding study periods.

XI. A special department for research, including a research school in each Presidency is most desirable.

XII. Private practice amongst officers of the Indian Medical Service in civil employ has declined considerably during recent years, though it is impossible to state in exactly what proportion it has declined. The decline in private practice is due to the increasing numbers and efficiency of Indian practitioners.

APPENDIX I.

SCHEME B.—PROPOSED MODIFICATIONS.

Paragraph 5.—*Percentage of ranks of Royal Army Medical Corps.*—Recommended that the seconding of Royal Army Medical Corps officers to the unified Indian Medical Service shall only be a temporary measure to exist until the full complement of the new unified Indian Medical Service is attained. If, however, it be decided that the seconding of Royal Army Medical Corps officers shall continue indefinitely, then it will be essential that the entrance examinations for the unified Indian Medical Service and the Royal Army Medical Corps shall be identical, and that Royal Army Medical Corps officers when seconded to the Indian Medical Service shall rank according to their positions at the entrance examination.

Paragraph 6.—*Royal Army Medical Corps.*—Volunteers permitted to join the unified Indian Medical Service must take their position according to the length of their service and not necessarily according to their rank.

Paragraph 7.—*Percentage of administrative appointments.*—This question will soon cease to exist if the seconding of Royal Army Medical Corps officers is only a temporary measure. Officers seconded from the Royal Army Medical Corps to the unified Indian Medical Service should be employed in military only, and should not be eligible for civil appointments.

Paragraph 8.—*The Director, Medical Services, appointment.*—Recommended that the Director, Medical Services, should always be selected from amongst the members of the unified service for an officer of Army Medical Service will in future have spent little or none of his service in India.

Paragraph 12.—*Anomaly of military promotion from civil.*—This anomaly will cease to exist if this scheme B is properly carried out (*vide* paragraph 17, last few lines).

Paragraph 14.—*Rank of Surgeon-General with Government.*—The Surgeon-General being the head of his department in each province should continue to rank as a major-general.

Paragraph 15.—*Seconded officers.*—Recommended that officers should be permitted to be seconded to civil after three years in military employ. Five years in military is unnecessarily long. The proposal that an officer in civil employ does not hold a residuary appointment should revert to military on attaining 20 years' service does not seem to be reasonable.

Paragraph 16.—No distinction should be made between civil practitioners and civil assistant surgeons. In any case it is advisable to omit the term 'English registrable qualification.'

Paragraph 17.—*Advisory Board.*—Recommended that the Advisory Board serving under the Government of India should consist of members representing each province and nominated by the local governments. A proportionate number of promotions and enhanced pensions equivalent to the pensions granted to holders of military administrative appointments should be reserved for officers holding residuary appointments, since these officers will be debarred from attaining military administrative rank.

Paragraph 20.—*Abolition of area allotment.*—Recommended that officers in civil employ should as a

rule be permanently allocated to one or other of the civil governments, since the habits, customs and languages of the people of India vary in different provinces.

Paragraph 22.—*Provision for the treatment of women and children.*—Recommended that the army and civil government should accept it as a principle that at least one European doctor of the unified service should be stationed in every military station and every civil district headquarters.

APPENDIX II.

SCHEME C.—PROPOSED MODIFICATIONS.

Paragraph 4.—Recommended that not only the military medical service, but that the military and civil medical services combined shall form one corps.

Paragraph 5.—Recommended that the Director General, Medical Service, shall be the head of the corps both military and civil, but that he shall have under him a Deputy Director General in charge of the military medical service.

Paragraph 6.—(c) *Executive officers.*—Recommended that seconding of Royal Army Medical Corps officers shall be a temporary measure and cease automatically when the unified medical service attains its full strength.

Paragraph 10.—*The administrative head of the Military Medical Service.*—Recommended that the administrative head of the military medical service shall be the Deputy Director General, Military.

An Army Medical Service officer should not be appointed head of the Indian Medical Corps.

Paragraph 11.—Recommended that with the establishment of a unified service—the Indian Medical Corps—all administrative officers shall be appointed from amongst the members of this corps.

Paragraph 15.—Recommended that a combination with the Royal Army Medical Corps maintained by seconding officers from the Royal Army Medical Corps to the Indian Medical Corps be only temporary, otherwise the service cannot be a unified service.

Paragraph 17.—Recommended that the words 'Other than the Royal Army Medical Corps' be omitted, but that if seconding of Royal Army Medical Corps officers to the Indian Medical Corps is to continue permanently then the entrance examination for all recruits, Royal Army Medical Corps and others must be identical.

The words 'Indians with indigenous qualifications only should not be eligible' should be deleted.

Paragraph 18.—*Conditions for Royal Army Medical Corps officers.*—As previously recommended the seconding of Royal Army Medical Corps officers should be merely a temporary measure.

Paragraph 22.—If Indian Medical Corps officers of the proposed unified service are, as suggested, compelled to revert periodically to military employ, there will be no objection to lieutenant-colonels in civil employ (excepting those holding residuary appointments) reverting to military administrative grade (*vide* paragraph 23).

Paragraph 23.—Recommended that reversion to military duty after five years shall be for a period of three months instead of six months as proposed.

Paragraph 24.—If paragraph 23 is adopted two months' course will probably be sufficient for training as an Assistant Director, Medical Services, whilst undergoing this course officers should draw the full pay and allowances of their substantive appointments.

Paragraph 25.—These examinations if introduced will not increase the efficiency of the service as a whole, but will render the service most unpopular.

It will also be almost impossible to carry out these examinations for officers in civil employ.

Paragraph 26.—*Promotion Board.*—Recommended that the Advisory Board should consist of members representing each province and nominated by local governments.

Paragraph 30.—*War reserve for the Indian Medical Corps.*—All officers whether lieutenant-colonels or not, except those holding residuary appointments, should form the war reserve.

12 March 1919.]

Major F. F. ELWES.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

Paragraph 37.—*Specialist in military employ.*—Röntgen ray, electrical and chemical experts, should be added to the list of experts.

Paragraph 38.—Recommended that after the words 'United Kingdom' the words "and India" should be added.

Civil medical service.

Paragraph 43 (i).—*Head of the civil medical service.*—Recommended that the head of the combined military and civil medical service shall be the Director General, Indian Medical Corps, under whom there shall be a Deputy Director General, Civil, who shall be in charge of the civil medical service.

Paragraph 43 (ii).—*Surgeons-General with the Governments.*—Recommended that the Surgeon-General of each province be selected from amongst officers in permanent civil employ in that province, unless there is no suitable officer available.

Paragraph 43 (iii).—*Inspectors-General of Civil Hospitals.*—The same principle should apply to the appointments of Inspectors-General, Civil Hospitals, as recommended for the appointment of Surgeons-General.

Paragraph 43 (iv).—*Executive medical officers.*—Recommended that officers in civil employ should consist of those seconded to civil from the military side of the Indian Medical Corps, and that there should not be a lower grade of officers. A subordinate medical service will, however, be essential.

Paragraph 44.—*Indian Medical Corps officers as civil surgeons.*—I am not certain of the meaning of this paragraph, but if it means abolishing the division into first and second class districts or civil surgeoncies, then I agree. This paragraph should, however, not apply to special appointments in civil, as for example, professorships at the medical colleges, bacteriological appointments, etc.

Paragraph 45.—Recommended that the probationary period in civil shall not exceed three years.

Paragraph 46.—Recommended that officers in civil employ should as a rule be allocated to one or other of the civil governments, as the habits, customs and languages of the people of India vary in different provinces.

Paragraph 47.—As recommended for B scheme (*vide* scheme B, paragraph 17), the Advisory Board serving under the Government of India should consist of members representing each province, and nominated by the local governments.

Paragraph 49.—The same principle should apply as that recommended in paragraph 44.

Paragraph 52.—Recommended that sub-assistant surgeons shall be granted the same length of study periods as recommended for assistant surgeons.

Questions relating to the Medical Stores Department.

2. I do not consider it would be a convenience if the Medical Stores Depots were made the sole source of supply except for urgent demands. I am strongly in favour of medical officers, at all events those holding special appointments, being permitted to obtain certain instruments, appliances and drugs, if possible, direct from the manufacturers.

Questions to be asked of service officers.

1. I have been two and a half years in military employ and sixteen and a half years in civil employ.
2. Yes, I have substantial cause for complaint or discontent with regard to the following:—

(1) *Pay.*—This has hitherto been insufficient, but I understand that an increase of 33½ per cent. has recently been sanctioned, which, if correct, substantiates the justification for the complaint as regards pay.

(2) *Furlough.*—Even before the war it was almost impossible to obtain furlough although such furlough might be long overdue. As an example I may state that I have had nineteen years' service, and the total amount of furlough I have received is four and a half months' furlough combined with two and a

half months' study leave in 1909. My case is not exceptional as there are other officers in much the same situation as myself as regards furlough.

(3) *Travelling allowance.*—The travelling allowance granted to officers in civil employ on permanent transfer to another station is quite insufficient to even approximately cover the cost of transfer. The consequence of this is that the cost of transfer from station to station has for the most part to be borne by the officer concerned instead of by the Government in whose interest the officer is transferred. The actual cost of transfer of an officer, his family and belongings should be borne by the Government.

(4) *Dual control.*—A medical officer in civil employ in an up-country station, although responsible for the medical organization of the district in which he is in charge, has no actual control over the subordinate medical officers under him. He can only recommend transfers and punishments to the President of the district board who may or may not carry out the medical officer's recommendations. This dual control sometimes leads to friction and may render almost intolerable the position of the medical officer who is responsible for the medical arrangements, and yet has no authority to deal with his subordinates.

(5) *Allowances when in military employ before passing the Lower Standard in Hindustani.*—Indian Medical Service officers are not granted an allowance even when in medical charge of a regiment if they have not passed the Lower Standard examination in Hindustani. This is a different line of treatment to that meted out to other officers in military employ, as for instance, Royal Army Medical Corps officers and Indian Staff Corps officers. Indian Medical Service officers should be granted the same concessions as are granted to other military services, and should be permitted to draw allowances for medical charge of troops, followers or cantonment hospitals, irrespective of whether they have or have not passed the Lower Standard examination in Hindustani. A reasonable period might be fixed within which period officers should be required to pass the examination.

3. Yes, I have met with instances of friction between the Royal Army Medical Corps and Indian Medical Service. As an example of friction between these services I may state that in my capacity as First Physician at the Government General Hospital, Madras, and as Presidency Surgeon of the 2nd District, Madras, it is frequently part of my duty to grant leave on medical certificate to Government servants. It has happened on more than one occasion that a Government servant who has been granted leave on medical certificate by me has been refused leave from military duty in the Indian Defence Force by the Royal Army Medical Corps officer in charge of the Indian Defence Force. Such occurrences are bound to lead to friction between the two services.

4. The only improvement I can suggest which will neutralise friction is the establishment of a unified medical service for India.

5. I consider that the limit of service for transfer from military to civil employ should ordinarily be ten years, though in exceptional cases it may be advisable to transfer an officer of more than ten years' service to civil. No limit should, however, be fixed for transfer from civil to military, provided officers in civil employ undergo compulsory military training every five years as suggested.

Special questions.

1. In my opinion the demands for European members of the public services in India for European medical attendance on themselves and their families is based

12 March 1919.]

Major F. F. ELWES.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

partly on racial predilection, partly on personal and social considerations, and partly on the professional merits of doctors educated entirely in the United Kingdom.

2. Europeans have certainly come in larger numbers to the Presidency town to obtain European medical

advice and treatment, since European medical officers were withdrawn from charge of civil districts.

3. I consider that the efficiency of Indian medical officers in various grades has certainly improved in recent years.

MAJOR F. F. ELWES, called and examined.

(Mr. Hignell.) He was not in favour of either scheme A or D; he preferred scheme B or C.

(General Giffard.) He did not think that an Imperial military medical service could be formed for the whole of the British Empire. He had not thought much about this scheme; but there were two main objections to it. One was that it would necessitate Indians being in the Imperial service, and they might not be willing to go to any part of the world. The second was that it would result in making the service less attractive than the old Indian Medical Service. In the Imperial service the pay would presumably be less and also pension. There would also be not much chance of civil work.

The chief attraction to many able candidates was the prospect of civil work; the high rate of pension was also an undoubted attraction. He would not advocate the formation of a purely civil medical service. It would not be popular. Though there were many who liked civil work, yet there were a certain number who preferred to remain in military. The fact that an officer had the choice of military or civil was a very important factor. Apart from this, he was doubtful whether officers recruited for a purely civil medical service would have the same standing as those recruited either for a unified medical service or for the present Indian Medical Service.

It was really an anomaly that the only avenue to higher promotion for officers who had been long in civil employ should be through reversion to military. The sooner this difficulty was removed the better. Experienced surgeons like Lieutenant-Colonel Niblock and experienced physicians should be allowed to rise in rank and pension though they remained in the civil line as consultants. In that case they would not expect to become military administrative medical officers.

They might revert to military employ as consultants but such appointments should carry enhanced pay and pension with rank up to full colonel.

If the present type of military assistant surgeon should be retained, they would have to be better educated than they were at present. Their primary education should be improved, Government meeting the extra expense. It was very necessary that they should be bound to serve for a stated period; otherwise many should leave the service after having received a free education. He instanced the case of a man who left the service in India, and went to England where he obtained a temporary commission in the Royal Army Medical Corps.

(General Giffard.) They should undergo a five years' course, at the end of which they might be given a diploma but not an Indian Medical Service Commission.

There were only two ways in which Government could give them a better education, (i) by providing a system of scholarships or stipends and (ii) by the establishment of a college for the whole of India. If the latter course were adopted, there would be an outcry. So he would prefer the system of scholarships or stipends.

(Mr. Hignell.) On the whole Indians would not make satisfactory substitutes for Anglo-Indians assistant surgeons. Some of them might but not many. The Anglo-Indian had qualities not found usually in the Indian—a certain driving power which enabled him to overcome difficulties, and was particularly useful on active service.

(General Hehir.) The L. M. and S. of Madras was a university degree, whereas in Northern India it was granted as the result of a Government examination.

If military medical pupils were given a full five years' course, and had to pass an examination equivalent to that required to obtain a registrable qualification, they would then be able to compete for the Indian Medical Service, and consequently the numbers of the Indian Medical Department would fall off. The reason why Government gave a free medical education to Anglo-Indians was that they required their services in the Indian Medical Department.

(Lieutenant-Colonel Bhola Nauth.) There would be objection from the Indian point of view if Anglo-Indians were to be educated at Government expense and trained as officers, when such privilege were denied to Indians.

(General Hendley.) Many of them could not afford to go to England. But if they knew that their prospects would be better by their going to England, they would make all possible attempts to save as much as they could during the first few years of their service. Anglo-Indians were not as necessary for the civil department as for the military. He was only speaking from the military point of view, although some of them are employed on civil duties in which he stated that the military assistant surgeon was very useful and difficult to replace.

(General Hendley.) Officers should be allowed to go into civil employ after 3 instead of after 5 years as was proposed in one of the schemes. He himself went to civil after a little over two years' service and he knew also of other similar cases.

At present the length of military service performed by officers before they obtained civil employment was different in different provinces. He would like to see some uniformity introduced for all India. A roster should be kept in which all candidates desiring to be seconded to civil should find a place and they must be prepared to go to any province according to their seniority and as vacancies occurred in the different provinces. But if any one preferred to go to any particular province, he would have to wait for a vacancy there. If, owing to an increase in civil requirements, the civil cadres of Indian Medical Service officers were considerably increased, the period spent in military before transfer to civil would be greatly reduced.

More provision should be made for furlough and study leave. At present the reserve for both leave and study was much too small. The granting of furlough when due and the introduction of study periods were also factors which would influence the rapidity with which men could be seconded from military to civil employment.

He was refused furlough twice in 1914. Though he did not formally apply in 1913, he asked informally for leave but was refused. The only occasion when he had refused leave was when he was offered 3 months' privilege leave during the cold weather.

(Sir T. Nariman.) He thought that in scheme C, paragraph 18, the words "Indians with indigenous qualifications only should not be eligible" should be deleted, as some of the Indian indigenous qualifications were registrable in England, and some of them were as good as English qualifications.

(Major Cramer-Roberts.) He considered that every one should revert to military duty for training once in every five years for about three or six months.

(Lieutenant-Colonel Bhola Nauth.) These periodical reversions to military might cause some dislocation to their work, especially if they were men of large private practice. On the other hand their obligations had to be fulfilled. When they entered the service they would

12 March 1919.]

Major F. F. ELWES.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

come in with a definite understanding that they would have to revert to military employ once in five years; hence that could not be called a hardship.

(General Giffard.) If the present Royal Army Medical Corps were split up into Indian civil and Indian military, there would not be many candidates for the military service as it would be unpopular. In that case assistant surgeons might wish to enter the service. He was speaking from the point of view of the London schools when he said there would be very few candidates desirous of entering the military service.

(General Hehir.) He did not advocate the policy of bringing in Royal Army Medical Corps officers periodically into the new service. It might be an advantage in a sense but it could hardly be called a unified medical service if this procedure was adopted.

He was not in favour of making promotions contingent on passing examinations.

He considered that the Director, Medical Services, should be selected from amongst the members of the unified medical service.

If either scheme B or scheme C were introduced with the modifications he had suggested, he was sure that the scheme would be popular and it might restore the service to its former prestige. If the best appointments were left to the service, he had

no doubt that it would attract the best candidates from the schools at Home.

He did not think that independent medical men in India were capable of carrying out the teaching work of the medical colleges in as efficient a manner as the Indian Medical Service had been doing.

(General Giffard.) He was not opposed to promotion examinations in point of principle for military medical officers in military subjects before obtaining administrative military appointments provided the necessary safeguards were assigned as to facilities for undergoing a suitable course in military organization.

(General Cree.) The system in vogue during peace time did not provide sufficient opportunities for medical men to improve or even maintain their professional knowledge, and this had led to an inevitable deterioration in their professional knowledge. A military medical officer should know not only all about surgery, medicine, etc., but also undergo military training.

An officer who had spent all his time from the 5th year to 25th year in civil life was not in his opinion fit to hold a high administrative military appointment. In order to overcome this defect, such officers should be reverted to military employ once in five years. Every officer in the Indian Medical Service after reaching the rank of lieutenant-colonel should be sent to a staff college, unless he was selected to remain in civil employ.

MAJOR J. F. GIBSON, I.M.D., Station Hospital, Madras.

Written statement.

Scheme C commends itself for the following reasons:—

- (a) The organization of the service paragraphs 4 to 7 appears quite adequate to meet all requirements and the composition of the rank and file, paragraph 8, best suited for Indian conditions.
- (b) The union of officers of the Royal Army Medical Corps and Indian Medical Service as described in paragraph 16 is to be highly commended.
- (c) The conditions for military assistant surgeons and military sub-assistant surgeons are very fair, when their duties in the Corps are taken into consideration.
- (d) The war reserve has been well worked out subject to certain conditions.
- (e) The organization of the civil medical service as described in the scheme appears sufficient for all present needs in India.

Higher appointments are open to officers of the Corps; this with employment in the civil and the increased rates of pay ought to attract a good stamp of recruits in the officer grade. It is very desirable to have officers of high professional attainments in the service. Admission by open competition to the best European and Indian candidates will be necessary to meet all demands of opinion.

In the middle grades of the service higher rates of pay with a demand for higher qualification is necessary to obtain a better class of recruits. In the lower grades, i.e., the rank and file, great care should be

taken to obtain a good class of recruit. I take it this could be secured by offering better rates of pay and a careful selection of recruits.

The scheme fulfills all the needs of the civil administration in India in peace times. In a great war this is almost certain to be affected unless there are certain safeguards, such as an increased war reserve from the military side or the formation of a special reserve in the civil. From experience I find that it would be very advisable to form a reserve not only in the officer grade but also in the lower grades of the civil medical service, such as the civil sub-assistant surgeon class.

The open system of competition for Europeans and Indians alike with military training in the Corps College is recommended. Specially promoted military assistant surgeons and the present honorary commissioned officers of the Indian medical department, after the period of special training should be incorporated as regular officers of the Corps, both in the civil and military side.

Post-graduate and post-collegiate study should be compulsory of all ranks. Special study leave rules should be made applicable to all ranks of the service. If the head of a department received an annual return showing the number of officers and subordinates who availed themselves of study leave during the year or attended a post-graduate course it would improve matters.

I have no suggestions to make regarding the provision of a special department for research.

MAJOR J. F. GIBSON, called and examined.

(Mr. Hignell.) He was not quite satisfied with his present position as a military assistant surgeon. He had a few grievances. Considering that he was a commissioned officer he expected better treatment. For example, a captain or lieutenant of the Indian Medical Department in civil employ is posted to a district under the district surgeon who may be an Indian Medical Service officer; the latter goes on leave and a civil assistant surgeon comes along and acts in his place, and the Indian Medical Department commissioned officer finds he has to work under the civil assistant surgeon.

They were not given suitable appointments. The commissioned officers of his service were usually treated as subordinates. They were never given independent charge of districts or hospitals. To his knowledge there were very few majors who received pay of Rs. 700 a month. They still got the same pay as a captain. His present pay was Rs. 450. They were promoted to a higher rank but they were given no extra pay. In a military hospital they did the same work as warrant officers. They rose in rank but not in duties. He was in sub-charge of a hospital in Madras and the same appointment could be held

12 March 1919.]

Major J. F. GIBSON.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

by a first class warrant officer. He would like his service to be given independent charge of small stations like Calicut, Cananore, etc. Then with regard to pension he would receive the same as a captain. He would complete 27 years' service in June. Pension could be taken after 25 years' service.

(General Giffard.) The reason why they were not given independent charge was due to their not possessing registrable qualifications. He suggested that future entrants should be given a five years' course in order that their qualifications may be recognised by the British Medical Council. After the completion of the five years' course they would be eligible to compete for the Indian Medical Service and Royal Army Medical Corps, but having regard to the fact that they were educated free by Government he would prevent them from competing by making them sign a bond.

He thought that, in the event of Government abolishing free medical education, not more than 25 per cent. of the Anglo-Indians who now enter the Indian Medical Department would be able to educate themselves at their own expense. There would be a falling off in recruitment if Government gave free medical education for a five years' course but demanded higher preliminary qualifications. At present there was no standard of qualification. The present lack of education in boys was due both to boys not studying and to parents not keeping them in school long enough.

(General Hendley.) It would be a great injustice to the community if the service was abolished. The service was much sought after by the average middle class Anglo-Indian. It was all the Anglo-Indian community could do to keep their heads above water in the race for life. If Government did not look after their interests he feared the community would be swamped. The community could not keep pace with the other communities of India. At present the service was a great boon to the community and it should not be abolished.

Civil employment was looked upon as the plum of the service. When he entered the service it was his sole ambition to enter civil.

The Royal Army Medical Corps rank and file should be confined to British station hospitals. In a combined station hospital—British and Indian—the Royal Army

Medical Corps and the Indian staff could never hit it off. There would always be friction and trouble. In such a hospital, even if the duties of the Royal Army Medical Corps, non-commissioned officers were restricted to discipline, and the assistant surgeons did the professional work, there would still be trouble.

(Lieutenant-Colonel Bhola Nauth.) There would be no friction in a combined station hospital if there were two sections—one British and one Indian—each confined to their own duties.

(General Hehir.) He had never worked in a combined field ambulance. He had worked in a combined base hospital. The staff consisted of Royal Army Medical Corps officers, Indian Medical Service officers, Royal Army Medical Corps sergeant-majors, nursing orderlies, ward orderlies, and ordinary nurses recruited from India. They all worked well together. When the duties of Royal Army Medical Corps subordinates and sub-assistant surgeons clashed there would always be trouble.

He had matriculated before he entered the medical college. In his batch they were all matriculates. During the last 25 years the education standard had lowered. The average boy when he entered the college was only about 15 or 16 years of age. Recently the age limit had risen to 17 and 18. He joined at 18 and passed out at 22.

At the present time the boys who entered the college usually came from the various European schools. The majority of these schools teach up to the high school standard.

The duties of a military assistant surgeon in a military hospital comprise supervising the nursing, dressing surgical cases, making up mixtures, taking temperatures, doing orderly duty, and attending to urgent cases. In fact, he practically did everything. Occasionally he went out with a small detachment moving by rail; at times he would be in charge of a training camp.

He was of opinion that the absence of much professional work lowered the prestige of the service from a professional point of view.

He was in favour of establishing a central medical college in a military centre, to be managed on military lines. This would be very much better than having colleges scattered all over the country.

No. 1285, First Class SUB-ASSISTANT SURGEON P. ANANTHANATHAM PILLAI, Banaglofe.

Written statement.

Answers to questions for sub-assistant surgeons.

1. Not satisfied.

Reasons:—

- (1) There is no such rank as warrant officer in the Indian army among the combatants and so no regard is paid to this rank.
- (2) The present grading was introduced at a time when the standard of education both general and professional was much below the present day standard.
- (3) Taking eligibility for a commission into consideration the present day sub-assistant is more eligible with his advanced general and professional knowledge for a commission than an average Indian officer who has generally received little or no education but who is always recruited from the ranks.
- (4) If pay is the standard of grading even then the sub-assistant surgeon of the last grade draws a pay that is not less than that of a jemadar who is a commissioned officer.
- (5) In private practice the holder of the L. M. P. degree has as much scope as any other university qualified medical man. But when taken to the military he is only a warrant officer.

- (6) In public functions a last grade sub-assistant surgeon since he is only a warrant officer is counted as something like a havildar which is too degrading to the profession.
- (7) Ordinarily the sepoys look upon the last grade sub-assistant surgeon as something like a lance naik and the 1st class sub-assistant surgeon of 25 years' service is counted something like a havildar. An ordinary recruit does not take more than 20 years to become a subedar-major while during this period or in the whole of his service, the sub-assistant surgeon is not necessarily made a commissioned officer. (Such people start as warrant officers and retire as such.) This humiliating condition stands much in the way of keeping up discipline and taking respect from the ranks of the Indian army.
- (8) A young sub-assistant surgeon is much humiliated by the treatment accorded to the rank he starts with and thereby he does not shine in the profession.

2. The study periods are very important. It is not necessary that the professional course of study should be taken in any separate institution other than the existing ones provided the curricula of studies are revised according to the advancement of science

12 March 1919.]

Sub-Assistant Surgeon P. ANANTHANATHAM PILLAI.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

and made uniform in all such institutions. The indiscriminate habit of recruiting newly passed out assistant surgeons towards the teaching staff of the medical schools and the hospitals attached therewith may be done away with and highly qualified specialists may be placed permanently instead. It is necessary that a sub-assistant surgeon should take post-graduate courses occasionally in the subjects in which he has got a special taste in fully equipped institutions for such branch. There is no necessity for opening a separate medical college for military students.

3. Yes. Such appointments will be popular and sought after because there is no scope for private practice and improving the professional knowledge in military.

4. The minimum qualification should be school final or any equivalent examination. The same standard should be maintained and brought into force in all medical schools in India. The degrees and diplomas granted by the Board of Examiners after passing the necessary examination from the school should be registered and recognised in the United Kingdom.

5. It will discourage recruiting if security is demanded as it is not every one who will be able to deposit security.

6.

7.

8. It will be popular and will have good effect towards recruiting, provided their early part of service is taken for such training.

9. Not satisfied.

(1) The period for retiring pension is too long. To serve as a subordinate in the military department for 30 years is very difficult if not impossible. A military sub-assistant surgeon has to undergo every hardship and face every danger of a soldier's life and has to serve on field service and in foreign countries which greatly tell upon his health. It is therefore represented that he should be given a retiring full pension after 25 years' service and invaliding pension after 20 years of service.

As for pay and scale of pensions see my answers to question 11.

(2) The present scale of family pension is very poor. A sub-assistant surgeon of 20 years' service drawing 110 Rupees if killed in action his family gets only Rs. 15 per mensem which is very insufficient for maintenance of family and children much less for their education. This should be half their rank pay as is the case with other combatants and non-combatants.

10. There should be a scheme. The sub-assistant surgeons will be willing to contribute provided their pay is increased.

11. (1) The present scale of pay for sub-assistant surgeon is inadequate for the following reasons:—

(a) Living at present is very costly.

(b) High cost of educating children.

(c) The military sub-assistant surgeons do not get any private practice.

The following scale of pay is suggested:—

1 to 5 years service	100	} Jemadar.
6 to 10 years service	130	
11 to 15 years service	170	} Subedar.
16 to 20 years service	230	
21 to 25 years service	300	Subedar-Major.

(2) *Field service*.—Fifty per cent. of the grade pay should be given as field allowance. Separation allowance and family pensions must be just like that of the other branch of the Indian Medical Department.

SUB-ASSISTANT SURGEON P. ANANTHANATHAM PILLAI, called and examined.

(General Hendley.) He recommended that military sub-assistant surgeons should be enrolled as commissioned officers. They should start as jemadars in the first place and after 15 years' service, they should be

(3) *Travelling*.—"E" Form must be allowed. Transfers and movements are frequent. Railway warrant now provided for travelling is inadequate. He has to defray extra expenditure from his own pocket which is a great hardship. All his pay and even more has to be spent in long shifts.

(4) The present quarters are too old fashioned and unfit to be occupied by families; the existing quarters should be modelled with more rooms and should be furnished. It is also requested that the present scale of house rent be increased to Rs. 15 and 25 respectively.

Reward for passing languages.

(5) The sub-assistant surgeon though he has to serve in different regiments and has to learn different languages is not entitled to any reward as in the other branch of the Indian Medical Department; request to grant the concession to this class.

(6) *Outfit allowance*.—An outfit allowance of Rs. 200 should be granted to the sub-assistant surgeon to equip himself. Though apparently this would seem a huge amount but if worked out it would hardly be just sufficient. It is further requested that for the up-keep of the uniform a clothing allowance of Rs. 36 per annum should be given in place of Rs. 12 as at present.

(7) *Detention allowance*.—It is requested that a detention allowance of Rs. 2 per diem be sanctioned to bear the burden of extra expenditure.

(8) *Sub-charge of Indian general hospital and hospital ship*.—(a) The sub-assistant surgeon was deprived of these allowances as an assistant surgeon was invariably posted for sub-charge in spite of Director, Medical Services' decision on this point, vide his no. 16553—2 (D. M. S. 3), dated 3rd September 1917, though there were sub-assistant surgeons to hold such appointments; hence request that no assistant surgeons will be posted to Indian hospitals.

(b) Medical and sub-medical charge allowances should be equal to that granted to the other branch of the Indian Medical Department since the responsibilities of duties are the same in both the cases.

(c) It is requested that a sub-charge allowance of Rs. 30 be given to Indian section hospital as in British section.

(9) *Rank of honorary assistant surgeon*.—The grant of honorary assistant surgeon after 15 years' service in the senior grade as mentioned in A. D. letter no. 12075—3, dated 18th May 1917, is quite meaningless. First of all we do not want honorary assistant surgeonship; what we want is the actual assistant surgeon's grade with all the accompanying privileges, concessions, etc. Secondly the phrase "after 15 years of service in the senior grade" is misleading. According to the present rules for promotion to the senior grade this phrase means that after about 40 years of service, one will become eligible for the grant of honorary rank of assistant surgeon; in this way it will be an impossibility to attain this honorary rank.

(10) *Representative of military sub-assistant surgeons with the Director, Medical Services in India*.—It is most essential that our class should have a representative at Army Headquarters where our destinies are solved and some times our interests are overlooked owing to the absence of proper representation.

12. Yes. Concession of having served in the military should not be taken into consideration towards admission of candidates who are lacking in general education, such as dressers and ward orderlies.

13. Vide my answers to question 1.

14.

15.

promoted to the next higher rank as subedars. Their next rank would be subedar-major to which they would be promoted after they had put in 20 years' service.

12 March 1919.]

Sub-Assistant Surgeon P. ANANTHANATHAM PILLAI.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

The present system of appointing junior assistant surgeons as teachers in medical schools was very unsatisfactory. Indian Medical Service officers should be appointed as teachers if they were available. If not, only the senior assistant surgeons, or those who had had some experience, should be appointed as teachers in these schools.

During the war, he had come in contact with a few civil sub-assistant surgeons. From the professional point of view, they were as good as military sub-assistant surgeons, though lacking in military training.

He could not tell why so many military sub-assistant surgeons had broken down in health at the commencement of the war. The military sub-assistant surgeons were not old, nor were they wanting in physical development.

The reason why he urged in his written statement that the degrees or diplomas granted by the Board of Examiners after passing the necessary examination from the school should be registered and recognized in the United Kingdom was that some men might like to go to England to read for the L. R. C. P. The object in aiming at a higher degree than was required for the service was to get private practice after retirement. As an alternative he said that he would be content if they

could get complete medical education in India with a five years' course of good training and if they get a diploma in the end.

(Lieutenant-Colonel Bhola Nauth.) He did not think that the military sub-assistant surgeons would be so completely broken in health as not to be able to practise after retirement. Moreover he had advocated in his written statement that they should be allowed to retire at the end of 25 years.

The present position of military sub-assistant surgeons was very unsatisfactory. If they were given higher and better preliminary education, and made jemadars, as he had suggested, and called assistant surgeons instead of sub-assistant surgeons, that would certainly be much more satisfactory. Their pay and conditions of leave should also be much improved.

(General Hehir.) When he started as a third grade military sub-assistant surgeon, he got only Rs. 25 a month. Their initial pay should be raised to Rs. 100 a month.

He considered that the student coming straight from the school was fit to take charge of a hospital in the absence of the medical officer. He did not think it absolutely necessary that any disciplinary training was required beforehand. That could be learnt while in the service.

MAJOR-GENERAL C. C. MANIFOLD, C.B., C.M.G., D.D.M.S., 9th (Secunderabad) Division.

Written statement.

Note upon schemes A, B, C and D.

As I have been requested to make a general reply on such matters as I am able to and not to take up the questions seriatim, I purpose dealing in bulk with these so far as an experience of 32 years enables me, and particularly the observations I have made during these recent years of active service as though antecedent causes may for a long time have been at work, it is during this war that the position of the Indian Medical Service in its relation to the existing scheme of medical services has become so parlous and caused such a state of grave despondency and utter feeling of hopelessness as its prospects fall upon its officers. No single one of the schemes put up with the papers forwarded, commends itself to me, as, in its entirety, likely to go far in remedying existing defects and meet the diverse requirements to remedy the present impasse.

But with the further information acquired from all sources available to this Committee, I am sure a good one can be formed out of B, C and D. After careful study of the four schemes, there appear to me in reality to be divisible into two:—

1. That under A or the Royal Army Medical Corps taking charge.
2. The remainder which all go to comprise an Indian unified service.

A would be a first class scheme regarded from the general betterment of the Royal Army Medical Corps. It should enhance its advantages and prestige, and raise the standard of its recruitment. Doing all this, it should meet with the approval of the War Office.

But I am also certain that this scheme will not satisfy the aspirations of the Indian in its proposed auxiliary corps. Nor will its proposed civil branch which except in the case of seconded Royal Army Medical Corps officers appear to be an entirely separate or subsidiary service carry enough prestige to attract the class of European medical man, which the Provincial Government and Government of India must desire to see come forward.

This scheme therefore although it tends still further to raise the prestige of a Royal Corps which already has recently been greatly enhanced, will leave the auxiliary branches, both European and Indian which it forms with much less standing than ever existed in the old Indian Medical Service, even with the loss of prestige the latter has sustained recently. The Indian's aspirations will

not be satisfied by such an auxiliary corps, which as far as can be seen will stamp him at once as a "second rater" whether regarded from the racial or service point. Hitherto, he has entered the Indian Medical Service, certainly when on its permanent cadre, as one of themselves, i.e., an Indian Medical Service officer and has received all the privileges and the prestige which in the past that service has had to give.

As such he was assigned by all the officers in the unit with which he did duty, whatever their natural race preference might have been, an unqualified reception. He was recognized as an officer who had passed for a King's commission in the Indian Medical Service and thus had earned without any marked reservation the official and social place which that service gave to all its members. Except for a very rare case of ragging or rudeness which might have occurred to a man whatever his race was, I have never myself known an Indian officer of the Indian Medical Service who was not satisfied that he was receiving the treatment and privileges an Indian Medical Service officer was entitled to, and who was not content to let his fortunes go with the prestige of the Indian Medical Service, certainly as its star stood until recently.

Is it likely, having up till now given him this, that the permanent Indian officer will be satisfied to be relegated to an auxiliary service of the nature proposed?

Next to consider the personnel of the civil medical service under A scheme. Again, though I cannot speak with quite such certainty I feel sure that neither the European nor the Indian medical man will regard this civil subsidiary medical service with sufficient pride to ensure the provincial government and Government of India, securing the best men, certainly not from the European schools.

I am presuming that civil emoluments are not likely to be increased to any extraordinary amount. That being so and members of the Indian Medical Service civil branches being at the present moment anything but contented even whilst they still retain the prestige which holding the King's commission undoubtedly confers, is this scheme likely to secure recruitment of first class men which whilst it holds forth none or little attraction in pay and prizes over those which they can gain in European civil life, yet gives none of the standing which at one time the Indian Medical Service conferred from the time almost that the student announced to his medical school and hospital staff that he was about to make it his goal, which

12 March 1919.]

Major-General C. C. MANIFOLD.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

leaves him in an inferior position to his fellow student who goes into the Royal Army Medical Corps and the latter even when seconded alongside of him cannot but fail to maintain the superiority his commission affords, and which when this auxiliary service doctor returns on furlough to his old colleges and hospitals or retires, will carry none of the prestige of the Indian Medical Service of old days.

Unless Government are going to pay very highly to compensate for all thus lost, it won't get the class of men required.

It is perhaps not fully recognised what weight the whole body of Indian Medical Service officers in civil employment many of whom entered the Indian Medical Service with permanent civil employment as their only goal attach to the continuing members of a military service, and this feeling is to be found strongest in those who are the most able, and professionally the best.

I can recollect well a man of this type who after a most distinguished career at London University had entered the Indian Medical Service with no other intention in view than a permanent civil career and who did only two years' military service, saying to me after holding for 15 years what was probably the most highly esteemed appointment in Calcutta that whilst he had been quite satisfied with his Indian career he could not for a moment contemplate the possibility of choosing a Government career in India as a pure civilian doctor, such stress did he attach to the independent position and prestige which from his own actual experience he had found such a great factor to his contentment and appreciation of his life under civil conditions.

Twenty-five or thirty years ago a man was able to say with pride that he belonged to the Indian Medical Service and whilst the brilliant and many of the really capable men of former days aimed at surgical opportunities and remunerative civil work, yet it was the prestige attaching to a grand military service in addition to those other baits which took them into the Indian Medical Service. But for this prestige those men whose only reason for not attaining to "Harley Street" and hospital appointments in London was the inability to hold on long enough financially would have preferred seeking their professional opportunities at large provincial hospitals at Home, or in good climates in Dominion cities. Is this inferior subsidiary practitioner's service going to appeal to this class of men? An occasional brilliant man may be attracted but the huge bulk that a medical service of this constitution will attract will be the most mediocre men. Whilst some brilliant men might with certain inducements be tempted to enter a service which was complete and self-contained in itself they certainly will not enter into this inferior one.

The effect in this war of the lowering of the relative status of the Indian Medical Service has carried the most disastrous effects with it and with such an object lesson in view it would be folly to experiment with a scheme condemning one branch to a position of distinct inferiority.

Again under this scheme of seconding Royal Army Medical Corps officers from what I know as Inspector-General of Civil Hospitals of the small stations which men have to put up with for 9 or 10 years of their service, I do not feel quite confident whether the good officer who can return to Home service after a bout of small stations is not exceedingly likely to do so whatever the original glamour of great opportunities for surgery, etc., may have been. However, this latter is somewhat of a minor point though well to consider.

B, C and D schemes which I group in one as representing the alternative of a unified service for India. This latter has distinct advantages and of course disadvantages also, but these latter should be capable of being overcome sufficiently to justify its acceptance.

The great and I think nearly the only advantage a scheme has over it, is that A allows of a constant polishing up of men by constant transfer Home for military work.

The Indian Medical Service in its professional aspect has hitherto held its own so well by the fact that men have been in the habit of devoting much of their furlough

in order to work in European hospitals and keeping touch with modern progress.

Till the regimental system with all its terrible limitations to an active minded man began to wane, the great possibilities which military hygiene and care of troops offered did not present much attraction for study to the average Indian Medical Service officer, and the idea except as it came into general public health of studying the latest development at Home in a military command rarely appealed to him. Things in this respect have altered much. Could not a system of exchange officers be inaugurated on a large scale, by which a fair number of the unified service officers might be transferred Home at about 7 and at 14 years' service to do duty in military hospitals for 18 months and a corresponding number of Home service men be sent out here for a similar time? This might, not only solve the problem of the officers of such a unified service keeping up with western modern ideas but also might solve the objection which always can be raised to such a unified system by the War Office, namely, that the same Royal Army Medical Corps officer may be losing the opportunity of gaining tropical experience unless he serves in India. At present there is, I believe, a system throughout other branches of the service of exchange officers with the Dominions.

Why not have this on an enlarged scale for medical officers between India and Home? The role, the Indian officer would play in this, would require careful consideration.

And until the policy of the army at large and in all its branches as to the Indian officers' future relative standing, and as to how any new Imperial policy is to affect this, is known, it will be difficult to formulate anything clearly. One can only see in a dim vista at present the possibilities his complete absorption into an Imperial body may give rise to. If such absorption is at all of a widespread nature it will be absolutely necessary that the medical officer of Indian birth should have taken out a course of at least two if not more years at a medical school in the United Kingdom before being allowed to compete for the service. In fact under any circumstances this should be a *sine qua non* of a unified service.

The matter of consultants and specialists is a very important one. That these should be appointed and that some should come out from Home is essential to a first-class service. Those from Home might be selected from rising men at the schools not necessarily the seniors brought out for 8 months' stretch, and if fresh selections were then made this should be an effective and not too expensive a scheme.

The medical services in France owe their most enormous amount of their effectiveness to the brains and constant flow of thought thus brought in.

Whatever scheme is introduced there must be an Indian Army Nursing Service for Indian hospitals, at least 4/5ths of which, if not more, should have had their training at Home.

In Indian hospitals these nursing sisters' duties will not be directly to nurse but to superintend the domestic economy of the wards, the regular feeding of patients, their cleanliness, etc., which a trained Indian Hospital Corps should carry out under their supervision. The number to a hospital need not be large. Without this service the Indian station hospitals will never attain their proper standard of efficiency.

A trained Army Hospital Corps is absolutely essential which should be carefully recruited. The present non-descript methods of recruitment which of course are only provisional are absolutely hopeless.

To sum up:—

The unified system of one medical service for India could I believe be formed and worked out—

To meet the demands of the War Office though I believe it would meet with tremendous opposition from the Home Authorities.

To meet all the requirements of the hospitals and medical school authorities.

To satisfy the needs of local administrations and lastly to be acceptable to Indians.

12 March 1919.]

Major-General C. C. MANIFOLD.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

There is a very striking statement made under B scheme that the Director, Medical Services in India, being always drawn from the Royal Army Medical Corps is the root cause of much of the discontent in the Indian Medical Service.

This is one of the only references to the serious state of despondency rather than mere discontent which exists in the latter service, but which indirectly has, I presume, had something to do with the appointment of the Commission. There must have been much more in the minds of the authors of this B scheme than appears in this simple statement, which, though they do not produce any evidence to support, is a statement of fact with which I agree. Now I should be glad with this point to take up questions 3 and 4 in the list of "Questions to be asked of service officers," and in considering them all in one and giving my views, I must, at the risk of being occasionally irrelevant, plunge into back history, if I am to give my opinion at all.

But first I think it necessary to find an explanation for the fact that, whilst a certain ferment of dissatisfaction with the existing state of things had been undoubtedly going on during 3 or 4 years antecedent to the War, suddenly within the first twelve months after its outbreak a terrible state of despondency and absolute despair at the prospects of the service fell upon nearly all its members, certainly of those up to about 20 years' service, so much so that whenever we went amongst them one heard regret expressed that they had ever entered it, and their intention to clear out of it as soon as circumstances would allow. I do not think I am exaggerating in the least in saying there was thus a most terrible hopeless state of despondency everywhere in the Indian Medical Service, and from early in 1915, my experiences which lay first in France, then in Egypt, then again in France, ending up with a visit to the Palestine front, confirmed the existence of this state of affairs, and a cursory acquaintance with various hospital ships manned by Indian Medical Service officers, who touching at many ports very often reflected the opinions of many others than their own, only further strengthened this impression. Everywhere was found the feeling that the Indian Medical Service officer was without any direct representative on any of the fronts who was in a high enough place to make himself heard, who would represent their feelings and see that injustices, whether accidental or as some said inflicted to fit in with a fixed policy of crushing the Indian Medical Service, as a service were remedied.

The Director General of the Indian Medical Service was too wholly removed from the war to be appealed to and if he had not been, was powerless beyond passing on correspondence which would have taken a year to filter through, and for which a Great War was not the time.

The Director, Medical Services in India, belonged to another service and whether quite baselessly or not was very often credited with anything but a friendly disposition to the Indian Medical Service as a service. In not a single theatre of war, no matter what had been the proportion of Indian troops, was there a single Indian Medical Service officer as adviser to the Commander-in-Chief of that front. To the indirect result of all these the Indian Medical Service officer whom I met, commonly attributed the fact that some failed to share the same benefits as did the Home service in consideration of their rank of the actual appointment held, and that others failed to attain posts which the particular talents and previous experience if they came from a civil appointment in some specialised line of work entitled them to, or anyhow not in the rank they had right to expect relative to what men of other medical services, men who were formerly pure civilians, of no better standing were getting because of attainments often hardly as good.

They felt they were in many respects receiving treatment as if they belonged to an inferior branch, and as a result could not hold up their heads as a service. All the more galling when they were meeting men of their own profession from every part of the world who had hitherto looked upon the Indian Medical Service as a picked service and who openly expressed their wonder and amazement, at its fallen state. The inferiority in

equipment, etc., of their hospitals also was very galling.

I think from the point of recruitment amongst the hundreds of young medical officers who were temporarily serving in the Royal Army Medical Corps (T) or Territorial and S. Reserve Forces, and saw this state of affairs, it was one of the worst advertisements the Indian Medical Service could have had.

Now I will come back to the point. I attribute much of this want of protection to the fact brought out in B scheme that there is never a Director, Medical Services in India, who belongs to the Indian Medical Service, and that this was used as a precedent in the various theatres of war. Before the war the fact that the Director, Medical Services, was always an officer belonging to the Home service was looked upon as being little more than a minor grievance. Something which would better things of each service should as a right hold in turn and which anyhow would be to the advantage of the Indian Medical Service to hold occasionally.

Such chagrin I remember being felt when Surgeon-General Harvey after having been on the headquarter staff of the largest frontier expedition of that day, and who was known to aim at the appointment of Director, Medical Services in India, in preference to that of Director General, Indian Medical Service, and whose brilliant talent and experience fitted him for the post, was not given it.

The first distinct rumblings of dissatisfaction, however, were felt when the old regimental system whilst not yet done away with in name began under pressure from about 1903 to fall into line with the prevailing British station system as authority began gradually to fall into the hands of the station senior medical officer and Assistant Director, Medical Services, and the latter who had hitherto looked upon the regimental medical officer of the Indian Medical Service as a man best left to deal with his own commanding officer without interference, began to tighten his authority through the senior medical officer.

About this period there was a feeling that over staff and cantonment appointments when an Indian Medical Service officer came up against a Royal Army Medical Corps officer in consequence of the former's seniority he was liable to be put quite out of the running by a transfer to another division. This sort of thing began whether true or not to unsettle the younger Indian Medical Service officer in military service and make him feel dissatisfied that he failed in the influence at Headquarters which the post of Director, Medical Services in India, would have given to the Indian Medical Service, and though during the very broad minded régime of Sir Arthur Sloggett with his genial personality there was little ground for complaint, this ferment had left its mark on the service in the feeling that continuous lack of representation was unfair to its interests.

But when the war broke out the effect of this tradition that the Indian Medical Service should not hold the highest military medical appointment was very quickly extended to the various seats of war where Indian troops preponderated, and it was generally believed that the interests of the Indian Medical Service officer were not looked after and kept up on a par with those of the Royal Army Medical Corps. Whilst I have no wish to quote my authority for the following statement I may say that I have every reason to believe it reliable.

It had been the precedent hitherto with an Expeditionary Force largely composed of Indian troops to appoint an Indian Medical Service officer as the highest advisory medical authority on the headquarter staff of the General Officer Commanding. This, though pointed out, I am told, to the Director, Medical Services in India, was not done before the expedition left. But as soon as it got to France a Royal Army Medical Corps officer was at once given this post with the Indian Corps Headquarters. After all it must have appeared natural to the Army Medical Service authorities to extend this policy of the Indian Medical Service officer never holding the highest appointment a little further down. And inasmuch as the Army Medical Service officer who

12 March 1919.]

Major-General C. C. MANIFOLD.

[Continued..]

(The schemes and questions referred to by witnesses are contained in Volume III.)

had been sent from India probably in ordinary course was senior to the Indian Medical Service colonel, the former become the Deputy Director, Medical Services, as soon as one was appointed. But what was done within three weeks of landing in France could have been done before the Expeditionary Force left India, and an Indian Medical Service officer appointed as Deputy Director, Medical Services. In Mesopotamia when Indian troops largely preponderated and later in Palestine, the post of Adviser to the Commander-in-Chief on his advisory staff at general headquarters was given to an Army Medical Service officer and not to Indian Medical Service.

All these I look upon as following the policy kept to in India of the highest appointment always falling to the Home service. Under these discouraging circumstances the Indian Medical Service officer, who was undoubtedly as compared to his Home service brother doing badly as regards acting rank and pay, felt he had no representative and that he was being dealt with hardly the whole way along the line, due to having no officer of his own service to represent him at headquarters.

Now with regard to the question about friction, I am of opinion that none existed between the bulk of the Royal Army Medical Corps and Indian Medical Service officers. They were brothers in profession with common work and aims, and it was fully recognised by the Indian Medical Service officer that, if he was being subordinated in prestige to the Royal Army Medical Corps and his pride of the service lowered, that this was not due to any unfair intrigue or action on the part of his brother officer and could only be attributed to a policy which placed his interests in the hands of those who possibly with the best motives were deeply tainted with the prejudice that the Indian Medical Service officer had not attained the standard of the Royal Army Medical Corps, and who dealt with him accordingly, and had no sympathy with the Indian Medical Service as a service, and I am forced to the conclusion that in the higher ranks of the Royal Army Medical Corps who had attained to Army Medical Service rank, there did in many instances exist a bitterness against the Indian Medical Service and desire once and for all to put it in a subordinate place.

Impatience and irritation, that a service full of men who often came from civil employment should have any equal claims, was I think most manifest, and whilst I would not say that any one was deliberately unjust there existed amongst men possessed of authority and influence a strong inclination to "down" the Indian Medical Service as a service possibly believing they did so with the best motives. Here again I must dip for a moment into past history in order to trace this feeling of bitterness to its origin or it might be thought that I was merely prejudiced and unfair.

The officers to whom this bitterness might be attributed were not to be found amongst the juniors as already said, but amongst those of a length of service which brought them back to a time when the seeds of bitterness had probably been planted. Thirty to thirty-five years ago the prestige both for ability of the bulk of its medical officers and for the interests afforded by their life were undoubtedly all on the side of the Indian Medical Service, and there was no question as to quality of the relative competition for the services. And the Indian Medical Service officer was not always as generous as he might have been in refraining from pointing out this disparity to the outside world (though the latter recognized it fully themselves) nor in repressing himself as to the narrow limitations that bound in those days and up to 18 or 20 years ago the Army Medical Service, as compared to the wide field the Indian Medical Service enjoyed.

I remember once a prominent civil surgeon of wide-spread Indian repute being attached to the office of an administrative medical officer at command headquarters for two months that there were usually jests when he turned up at the club lunch table by the club wits as to what he had learned in which he was not at all averse to join in a similar vein at the expense of the

office. This sort of spirit was too widespread; I give this instance here as being typical of the mistaken spirit which was naturally most galling to the really earnest Army Medical Service officer of that day who were building up that service into the well-organized and efficient corps it became, and undoubtedly over this sort of thing the sting rankled. Suddenly as the result of the South African War lessons and of the accumulated labours and extraordinary zeal and persistence of some of their really good men with the backing up of the medical schools, the whole of military hygiene, and medical organization and work shot ahead, and before the Indian Medical Service officer had completely realized it, it had become a military service recognized by the best and the most highly placed soldiers as worthy of the most careful study and highest consideration.

The Royal Army Medical Corps officer now came in for his own. But the officer of the days I have alluded to, as the good men rose to the top with the weeding out which occurred after the South African War was not likely to be averse to get something of his own back. Particularly if through prejudice he was under the possibly honestly held and mistaken belief that the Indian Medical Service was a hybrid service not fitted for a moment to be classified with his own as a military one or to undertake administrative responsibilities in a mixed military force.

Thus with the Royal Army Medical Corps having the upper hand comes the present phase in which there was a tendency in some quarters to make out that the Indian Medical Service as a service had been left entirely behind and was generally in a retrogressive state and that none of its officers had retained the capacity nor had the training to run any military medical organization. As a sort of concession, certain military administrative appointments had to fall to it in India, but anything outside these should certainly not fall to it, and with this was also a tendency to neglect to see that junior officers of the Indian Medical Service received the same consideration as the Royal Army Medical Corps; whether I am correct or not in assuming this to be the attitude of some, certainly the results to the Indian Medical Service during this war were conducive to this belief.

When views so damaging to the Indian Medical Service, were honestly held by prejudiced people who often had the power to put them into force they were likely to do so without thinking for a moment that they were doing anything but dealing out justice, if possibly retributive justice. Human nature being such, as it is, self-aggrandisement becomes very natural especially when it is a matter of exhibiting it in advancing the interests of a service even at the expense of another.

But I was not in a position myself except for a comparatively short time to come up actually against these adverse waves which the Indian Medical Service, were being subjected to, though when I did so personally I realized their undoubted submerging force on the Indian Medical Service officers.

Throughout the War I was myself serving with either British or Dominion formations only. Apart from any of my own personal experiences of disadvantage attaching to the Indian Medical Service officer I can give one or two instances of which I was cognisant in France. One of these was in April 1915, when on reporting myself in France for duty I was instructed by Sir A. Sloggett to visit the Indian general hospitals in the Boulogne area. Here I found a Royal Army Medical Corps officer with the title of senior medical officer, Indian hospitals. Such an appointment with such a nomenclature had never been known elsewhere, and if it were necessary to make such a post under the Assistant Director, Medical Services, it should naturally have fallen to an Indian Medical Service officer.

But even so, one might have expected to find a very brilliant organizer in the person of the Royal Army Medical Corps officer holding the post. But the man who held it at the time I speak of was not held in any high estimation by his brother Royal Army Medi-

12 March 1919.]

Major-General C. C. MANIFOLD.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

cal Corps officers. In fact he came under what is popularly known as the "Dud" category.

The history of this appointment though dealing with extraneous matter to some extent bears sufficiently on the whole question to be worth relating here. I can only give facts as related to me by men who had been through the experience and felt it bitterly. An Indian general and an Indian stationary hospital were sent to Boulogne in the winter of 1914.

It was dumped down in very unfavourable weather on a site about two or three miles out, part of which was swampy. Coming in as strangers and rather outsiders a unit like this to set up properly required from the start a great deal of sympathetic assistance. Those who are acquainted with campaigning in France will appreciate how much always had to be given to an unit like this over and above that laid down in its mobilization tables. Engineering supply and ordnance equipment had to be poured in and outside fatigue parties, etc., if as a general hospital it was to make any successful show quickly. I know from my own experience what very much smaller units had to have, if they became stationary for any time. But I was able, having the authority of a corps headquarter (administering five Divisions as well as 30,000 Army troops) to assist such units. Officers of this Indian hospital at Boulogne told me that at the start not a single facility was afforded to them; and that over and above what they could produce from their own resources or their regulation equipment they could get nothing, and on going to the local medical administration, no practical sympathy was forthcoming beyond a curt reference to mobilization tables and a query as to what other units did.

Even transport to get up equipment from the railway station which came after the first lot had arrived could not be obtained and only by going to the "Red Cross" could the necessary lorry be procured after some days' delay.

After a fortnight or three weeks' struggling with difficulties which an authoritative request from the Assistant Director, Medical Services, for assistance to the engineer or other branches concerned would probably have removed, at once down came a higher medical authority who I was told by the officers of the unit administered to them a merciless castigation dwelling, they said, on their defects as Indian Medical Service officers in a way in which they told me they all felt insulted as a service. And a Royal Army Medical Corps officer who was undoubtedly a thruster with absolute full powers to call upon every branch and department for which he required was put in with the new title of senior medical officer Indian hospitals and the officer commanding the hospital was sent away under a cloud and another put in.

Stimulated by an immediately impending royal visit to the Indian hospitals and by the prospects of any Army Commanding Royal Engineer or Supply or Ordnance officer who failed to give ready assistance getting his embarkation orders for the first steamer back to England, there is not much wonder that an effective and well organized hospital rapidly sprang up and to those unacquainted with history it probably became a movement of what under direct Royal Army Medical Corps administration, an Indian hospital could attain to.

Now this was an incident which could be easily be made out to the detriment of the Indian Medical Service as a service. Amongst some individuals there would have been a ready inclination to do this, detraction not with purposeful injustice but because they looked upon it as a righteous action and in the welfare of efficient administration, to crush what they considered were the anomalies and inconsistencies of the Indian Medical Service and give it no chance of surviving this War as a service with any military repute for efficiency.

It was this sort of thing that created the great despondency, despair, that could be found everywhere amongst Indian Medical Service officers and though my

experience was limited, I was forced to the conclusion that there was a good deal of suppression of the Indian Medical Service for this feeling to be so acute; and over incidents which could only be cleared by carrying up representations to an extreme, there was the fine spirit abroad that the War and particularly that stage of it was not the time to create factions by bringing up grievances. But men whilst they submitted by force of circumstances became heart broken over them.

Shortly after this, this particular Royal Army Medical Corps officer was for his ability promoted. But no Indian Medical Service officer was given a chance of succeeding to the appointment of senior medical officer Indian hospitals. The Royal Army Medical Corps officer who came under the popular classification I have given previously was considered good enough to fill the appointment.

Every officer in this hospital felt terribly distressed, they told me for their late officer commanding knowing the way he had been handicapped and they felt, they themselves were discountenanced and hardly treated as a service.

I wrote a personal letter to Sir A. Slogget as to the anomaly of keeping a Royal Army Medical Corps officer in this post and the latter shortly afterwards was transferred.

Sir A. Slogget in India had always had the reputation of being very fair to the Indian Medical Service over appointments, etc., and unless some general policy frustrated him would, I am sure, have been equally so in France.

But what the Indian Medical Service required was some senior officer on the spot who would have had direct access to Sir A. Slogget and to the War Office and India Office. The Dominion Forces were well represented in this way.

But the fact that in India it was always considered quite sufficient to have a Home service officer perpetually representing the Indian Medical Service interests could always be used as a precedent against any such step, and nothing of the sort was dreamed of, anyhow nothing was done.

There were however other peculiar and more important interest besides those of the Indian Medical Service as a service involved, and the fact that no officer of the Indian Medical Service could as things stood, carry sufficient prestige and weight to enforce attention to them apparently became evident at Home and another anomalous appointment was made which excellent as it was in ensuring that the objects aimed at should be attained, yet added a further push to the tottering condition of the Indian Medical Service as a service.

Sir Walter Lawrence was sent out to France in some sort of extraordinary appointment to represent the interests of the Indian hospitals there.

Now no one could cavil at a man of his ability, power, and influence holding any appointment. But something must have been radically wrong with the organization of the Indian Medical Service if, either one of its own officers was not capable of representing Indian hospital interests or would not be tolerated or listened to by the medical authorities as an Indian Medical Service officer. And it was lowering to the prestige of the Indian Medical Service in the eyes of other branches in France, and the idea of such an outside appointment being made, though not the individual appointed, was humiliating to its officers. I cannot imagine the Home medical service welcoming a pure layman to represent the administration of its hospitals or its being tolerated by their representatives; there is little doubt but that it was a most useful, and in the existing state of affairs very necessary appointment, and that Sir W. Lawrence was able to enforce attention to essential demands in a way that allowed of little delay. It may have been recommended by the India Office, but it was only necessary because of faulty conditions originating from the bad precedent in India. But he was unacquainted with the inner working of the Indian Medical Service as a service and its intimate

12 March 1919.]

Major-General C. C. MANIFOLD.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

feeling particularly as relating to other branches and free resort therefore on these points was not made to him. A man has to come to a very bad pitch indeed before he puts up to an outsider what is breaking his heart over his own service.

I have no doubt Sir W. Lawrence never heard a third of what the Indian Medical Service looked upon as indignities and probably he eventually gave up the post feeling that he had striking evidence in the Boulogne hospital of the superiority of the Royal Army Medical Corps officer if not indeed of the incapacity of the Indian Medical Service officer to administer a military matter.

The Marseilles Base was another instance which came to my direct notice of the Indian Medical Service suffering from the policy that the Indian Medical Service officer should not hold a military administrative appointment which it was possible to put in a Home service officer based on the precedent in India.

Marseilles Base was the only place in France where there was an enormous preponderance of Indian troops over British at ordinary times. When I passed through in 1915 and again in 1916 (and I believe this had almost always been the proportion), there were of all ranks taking in officers and supply depots, etc., about four hundred British troops and about four thousand Indians and large Indian general hospitals.

There was in consequence of this an officer of the Indian army in command of Marseilles Base and it should have been only right and natural to have had an Indian Medical Service officer appointed as Assistant Director, Medical Services, on his staff.

But this was not to be permitted. An officer of the Home service who had had I believe no acquaintance with Indian troops for twenty years was appointed, and given a comparatively junior Royal Army Medical Corps officer as the Assistant Director, Medical Services, who had the pay and position. But so evident was the necessity for having some one who knew something about Indian troops and their ways on the Assistant Director, Medical Services' staff, that a first class Indian Medical Service officer was introduced into the office to cope with deficiency which were so evident in this personnel. And the local impression was that largely to this Indian Medical Service officer's efforts and knowledge was due the credit of the excellent arrangements for Indian troops and hospitals in Marseilles.

I am glad to say that later on in the War, I believe, when in another theatre he was awarded a distinction, but it was not till long after the junior staff officer had been rewarded to whose success he had contributed so essentially and whose appointment in the minds of the people on the spot he

should have been holding, certainly all Indian Medical Service officers were entitled to this opinion.

Later at Marseilles an Indian Medical Service officer was appointed as Assistant Director, Medical Services, in 1917 for nearly a year. The General Officer Commanding at Marseilles told me he had done splendidly and he had already had a fine record in France.

But during all this time he was persistently refused the rank of full colonel which the appointment would have anywhere else automatically carried.

I do not think that any Royal Army Medical Corps officer would have been allowed by his own people to hold an administrative appointment at a large base without being given the rank of colonel at once. I never knew of it anywhere else in France. And any senior lieutenant-colonel after being tried for one year in such an appointment, and having done well would have been left in it.

But this particular Indian Medical Service officer after holding it for a year with great success was ejected to make room for an Army Medical Service officer for whom some post as a senior man was required.

I was much struck by an ex-British cavalry officer who had been General Officer Commanding at Marseilles and who could have no particular sympathies with the Indian Medical Service spontaneously saying to me that from what he had seen in France the Indian Medical Service were not given fair deal by the Royal Army Medical Corps.

As a senior officer of the Indian Medical Service who has personally whilst serving with Dominion troops during the War been brought into close contact with and been on cordial terms with nearly all the officers of the Army Medical Service holding high appointment, I dislike very much to appear in any way to be making unfriendly deductions. But it is absolutely forced upon me that an animus against the Indian Medical Service existed amongst many of them and a desire once and for all to relegate to an inferior position a service whose minor organization and working they disliked unless possibly with the best of motives.

I have given these instances just as they came to me on the few occasions. I came into contact with Indian formations and have avoided drawing upon any of my own individual experiences upon whose bearing upon this question I might have distorted views. Possibly I may have brought in matter extraneous to the objects of this committee, but only when it has borne upon this harmful system quoted in scheme B of subordinating the military side of the Indian Medical Service in India by never allowing it to have its own representative as Director, Medical Services, in India. It is this precedent which has given rise to each harmful results I believe in this War to the Indian Medical Service.

MAJOR-GENERAL C. C. MANIFOLD, called and examined.

(Mr. Hignell.) His chief objection to scheme A was that it did not make sufficient provision to meet Indian aspirations. If, however, the Royal Army Medical Corps would open their ranks to Indians and grant them full membership there would be no objection from that point of view.

The fact that the Director, Medical Services in India, had never been appointed from the Indian Medical Service had had a very adverse effect on that service.

(General Cree.) The statement of a highly-placed military official, to the effect that an Indian Medical Service officer who had been for a long time in civil employ did not, on his return to military, make a good military medical administrator, was likely to be true in the case of officers who, after transfer to civil, had never thought any further of military life. There was a certain type of officer who not only entered the service in order to go to civil employment, and who, when he had got there, washed his hands entirely of

the Indian Medical Service as a military service, and took no pride in it. The number of such officers was small, but they were not a credit to the civil side of their service. They were persons who had no aspirations above that of an ordinary practitioner. To remedy this evil he would fix a stage beyond which an officer should not return to military duty. An officer should return to military every fifth year for a period of 8 to 12 months, in order to keep himself efficient in military affairs. If during that time it was found that he was a type of officer who would not take an interest in military matters he should not be placed, except for certain purposes, on the military cadre at all. As a last resort he could be called out as a reserve, possibly for duty in hospitals in India. He should also be debarred from military rank.

As regards the suggestion that every Indian Medical Service officer, unless he elected entirely for civil or was in one of the reserved civil appointments should on

12 March 1919.]

Major-General C. C. MANIFOLD.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

attaining the rank of lieutenant-colonel go to one of the staff colleges for a course of study, he agreed with the general proposition that officers of the medical service should mix with officers of other services, and keep themselves acquainted with developments in all branches of military service. He saw a great deal of that in France where officers used to lecture on different subjects.

Probably some Indian Medical Service officers did not realise what were the duties of an administrative medical officer, but there were possibly officers of that stamp in other services also.

It might be desirable that specialists who were well-known as physicians and surgeons should be given the opportunity of promotion to higher ranks, at the same time allowing them to continue their special work, by appointing them as consultants to the army in India. This should, however, be restricted to very exceptional officers who were really specialists. The average officer, however, who took a real interest in his work, would take an interest in both the civil and military aspects of it. He was rather inclined to think that ordinarily an officer who desired to be promoted to the rank of colonel or major-general, without taking up administrative work, was one who had not succeeded as a clinician and had proved a failure as an administrator.

(General Hehir.) He had discussed service questions with many officers whom he had met during the late war, and had come to the conclusion that there was a feeling of hopelessness and despondency among the members of the Indian Medical Service with regard to its present and future prospects.

A combination of schemes B, C and D with certain modification would meet the civil and medical needs of India.

It would not be possible for the Indian Medical Service to recover quickly from the shock it had sustained during the last few years. There had been a tremendous shock not only to the Indian Medical Service but also to the medical schools in England, and the service was at present so discredited in the medical schools that it would be very difficult for it to recover its former popularity.

If Indian students were to be successful as officers of the medical services, they should have had some training in a European medical school.

If there was to be a further Indianization of the service, it would be necessary to fix definitely the number of Europeans who should be retained in it for the next 15 years. The number of Indians to be taken into the service should also be laid down, but he did not like to suggest any figure.

Nursing as at present conducted in Indian station hospitals was extremely defective, and he had seen men dying for want of care as there were none but raw recruits to look after them. This branch stood greatly in need of reorganization. Nursing sisters should be introduced for professional work, and for the training of male nurses, and should form part of the establishment in future. Once there were well-trained orderlies working under supervision, the supervision by nurses would not be required to any large extent.

He could not speak from direct personal experience about the grievances of the Indian Medical Service but references to this question contained in his written statement were based on what he had heard from officers of the service who could be relied upon. The feeling of despondency which prevailed in the service before the war had since been intensified. Indian Medical Service officers were not given the same chances as Royal Army Medical Corps officers. The seeds of this policy of unfair treatment of the Indian Medical Service were sown 20 or 30 years ago, and were now bearing fruit, as officers of the British service who had a feeling of bitterness against the Indian Medical Service from early days had now come to occupy high positions. Recruitment for the Indian Medical Service had then been of a higher standard, and its members did not refrain from express-

ing their opinion about the inferiority of the Army Medical Service. The feeling at present against the Indian Medical Service was that it was a hybrid service, as its officers were performing civil duties as part of their career, and the Royal Army Medical Corps did not want officers who could say that, in spite of having spent a long time at civil work, they were as fit for administrative posts as the Royal Army Medical Corps. There was a certain combination of individual officers who were out and out against the Indian Medical Service. One of the grievances was that an officer could not look to the head of the department, who did not belong to this service, in case of hardship.

The combination of British and Indian station hospitals under one organisation would not differ very much from the present system of having the Assistant Director, Medical Services, administering the two hospitals. He could not perform both duties, and must have some one under him as second in command which was the position held by the Assistant Director, Medical Services, in certain stations. At present with one commanding officer looking after all hospitals there could be two or three section hospitals connected with a British station hospital. Being asked whether it would be practicable to go a step further and include all the Indian station hospitals under, the same officer, he replied that this would be practicable with a unified service, but could not be done without friction, so long as the two services existed in India. He did not advocate the pooling of the two services for general work in a station, as this could not be done without friction until we had one service only.

He favoured the institution of examinations for promotion from captain to major, but could not express an opinion without further consideration as to the advisability of examinations before promotion from major to lieutenant-colonel, as many factors had to be taken into account, namely, the question of officers in civil employment, what the new scheme was to be, and the fact that the Indian Medical Service was just now entering more or less on a new phase.

He had considerable civil experience. As Inspector-General of Civil Hospitals in the United Provinces he had about 15 military assistant surgeons under him. Some of them were very good, though not absolutely first class, from the point of view of medical administration of a district and he had always had great sympathy with them. They had been very much handicapped, like the apprentices in old times in England who were refused certificates and were tied down to low wages. The military assistant surgeons were on all-fours with those apprentices and had practically the same education as the latter. They were kept down low in the scale of life.

(Mr. Hignell.) Their standard of education should be raised if they were wanted for the military hospitals, though personally he was of opinion that they were not required. They were, however, very useful to Government and could be and were used as cheap substitutes for doctors for duty with small parties of troops. They could be replaced by a possibly more expensive agency. Strictly speaking the military assistant surgeon's work in hospital was connected with minor duties in administration, though he saved a lot of work to the medical officer. In the latter's absence he could attend to serious cases, sending for the medical officer if necessary.

(General Hehir.) With a good unified system an Indian Medical Corps could be brought about without difficulty. Apart from the question of unification he saw no objection to the conversion of Indian Medical Service into a Medical Corps.

The independent medical profession as at present constituted could not carry on the teaching work in the medical colleges as well as Indian Medical Service officers.

If properly qualified lady doctors were employed, and if they were supplied with motor cars which would enable them to meet the demands of European ladies some of the present civil surgeoncies could be

12 March 1919.]

Major-General C. C. MANIFOLD.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

abolished. This, of course, presupposed the existence of good communications.

(Colonel Bhola Nauth.) He did not admit that there had been a breakdown in the Indian Medical Service.

His experience did not bear out the statement that Indian Indian Medical Service officers had any complaints about the treatment accorded to them, or that such complaints had reference to officers of their own service. Generally an Indian Indian Medical Service officer did not come very much in touch with other officers because under the old regimental system the Indian officer was attached to a regiment. As regards the complaint that their claims to civil surgeoncies in first class stations, such as Cawnpore and Allahabad, were ignored, he pointed out that there was only one Indian officer of the Indian Medical Service in the United Provinces. He was in civil employment, but being junior, was not entitled to a first class station.

(General Giffard.) A unified military medical service with officers in civil employ for the whole of India which would mean the exclusion from India of the Royal Army Medical Corps as it existed at present would be feasible, provided that the officers of that service were constantly required to go to Europe to keep in touch with military administration there. It could only be worked gradually and could not be introduced at once. The first step should be the transfer to the Indian Medical Service of Royal Army Medical Corps officers, who volunteered but this would depend on the number of such officers who were willing to transfer. He would also second a certain number of Royal Army Medical Corps officers to the new service. No doubt seconding would mean that an officer would have to come into this service by order against his will, but there would be no harm or hardship if he did so for the first few years. In that way it would take five years to introduce the scheme. The Royal Army Medical Corps should not be abolished completely as the work must be carried on, so there should be gradual evolution.

Civil employment was good for officers of the military medical service so long as it was not carried to such an extent that they lost touch with the army.

As regards the periodic military training of officers in civil employ, in order that such officers should be kept militarily efficient without the work of the civil department being dislocated, he suggested that they should go to military in their 10th and 15th year of service. Assuming that an officer went to civil between the 5th and 6th year of his service, he

should be reverted again to military in the 10th and again in the 15th year, for a period of 8 months or a year. He should be attached to a station hospital, and should be made to pass a series of tests or examinations in all forms of hygiene and sanitation. He should come into intimate relationship with the soldier. The importance of this had been prominently brought to his notice during the war.

At present the only way in which the majority of officers could be promoted to the rank of colonel or general was by leaving civil employ and taking up a military administrative appointment. Instead of that it would be better to establish a corps of consultants in which medical officers could reach the highest rank. The avenues to this corps would have to be guarded very carefully, and selection made with very great caution, as the selected officers would have to act as advisers. There would be no risk so long as there was careful selection. There would be the danger of selecting a surgeon, say from Calcutta, who had performed a number of operations, but who was not likely to be a good consultant. It was quite possible that a very good surgeon in a London hospital might not be suitable for service in the field.

(Mr. Hignell.) The exclusion of the Royal Army Medical Corps as a corps, from India, in connection with the formation of a unified military medical service, would meet with great opposition from the War Office. If, however, that opposition were got over the unified medical service would need to be made very attractive to induce members of the Royal Army Medical Corps to volunteer for appointment to it. There would be a feeling among them that they were giving up their service, and for some time they would be looked upon as inferior. He did not see any strong objection to seconding them for service in the unified medical service as it was not contrary to their warrant.

(General Giffard.) The prospects of recruitment for the Indian Medical Service were at present very poor. There might be a certain number of young doctors who had been on active service and who would prefer to continue in the army rather than go back to civil work. They would join the Indian Medical Service but within two years they would be dissatisfied, and the service would not get any more recruits. The prospects of the service would have to be considerably improved in order to make it attractive. The fact was that the prestige of the service had fallen, and this was of greater importance than the question of emoluments.

MAJOR A. W. J. LYNDALE, I.M.D., Medical College, Madras, called and examined.

(General Giffard.) With regard to the future reorganisation of the Indian Medical Department the witness stated that in the first place the standard of education should be raised. Students should not be admitted into a college unless they had passed the Senior Cambridge test,—a test which was recognised by the General Medical Council. Secondly, the age limit must be raised. At the present time boys came in at 17. Being so young they had no will power and consequently they did not appreciate their condition. They did not realise that they were military pupils studying for their future and for the good of the service. They were under the impression that they entered a college for the purpose of amusing themselves. Boys should be admitted at the age of 19. At this age they would realise their position better. He would keep boys in school longer and give them a better education.

If Government gave them a five years' course, free of charge, the Government would be entitled to their services. If they resigned they could be tried as deserters under the Army Act. They should be bound to Government service for 10 years and then given a free hand. It was not likely that an assistant surgeon of 10 years' service would resign.

In the absence of the commissioned officer the assistant surgeon had to do all the professional work

in a station hospital. If the service was improved he could be made a sort of local medical officer.

In the event of Government abolishing the military assistant surgeon class, the Anglo-Indian community would find other employment. He did not think the Anglo-Indian community were in a position to educate themselves.

(General Hendley.) He was dissatisfied with his present position. Commissioned officers of the Indian Medical Department had not been treated at all well. They were looked upon as subordinates. He was a major of 38 years' service and he received the pay of a captain. There was no increase of pension; the pension is the same as for a captain.

The prospect of civil employment was not considered an attraction to those entering the service. As a matter of fact students when entering a college knew very little about civil. He admitted that most put their names down for civil, but this was done simply because they knew that they could not get to civil straight away.

(General Hehir.) The military pupil ordinarily came from the Anglo-Indian community. At present those in the Madras Medical College came from St. Joseph's College, St. Mary's College and the Adyar Orphanage. The majority of the colleges teach up to the high school standard and the Senior Cambridge. The Doveton

12 March 1919.]

Major A. W. J. LYNSDALE.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

College teaches up to the First Arts. About half a dozen boys came from the Doveton. If a higher standard of education was demanded by Government he thought that boys would still come. Very many boys who presented themselves were certainly not Anglo-Indians, although they said they were. It has been very difficult to prevent the entry of this class of boys into the service. They usually come with a certificate from a priest, who certifies that their grandfather or grandmother were Europeans.

If the five-years' course were adopted, some provision, should be made, in the shape of scholarships, for brilliant boys in order to enable them to compete for the superior service.

He had no objection to the removal of the 4th grade from the service.

With regard to the statement that assistant surgeons got very little professional work in British

station hospitals, witness stated that as a matter of fact there was very little professional work to be done in these hospitals. During the whole period of his service in the army only two serious cases came under his observation.

The introduction of the Royal Army Medical Corps rank and file into India would affect the position of the assistant surgeon in a British hospital. They would never be able to work together. They would constantly clash.

(General Hehir.) If Indian military assistant surgeons had to work in British station hospitals there would be considerable difficulties. The first thing a British soldier looks to is colour, and he certainly would not like to be under the orders of an Indian assistant surgeon. If trouble occurred between the Indian assistant surgeon and the soldier, the soldier would be blamed. The employment of Indian assistant surgeons in British station hospitals would never be satisfactory.

[13 March 1919.]

Dr. M. R. GURUSWAMY MUDALIYAR.

*(The schemes and questions referred to by witnesses are contained in Volume III.)***At Madras, Thursday, 13th March, 1919.**

PRESENT:

S. R. HIGNELL, Esq., C.I.E., I.C.S. (*Presiding*).

MAJOR-GENERAL G. CREE, C.B., C.M.G., A.M.S.

MAJOR-GENERAL P. HEHIR, C.B., C.M.G., C.I.E.,
I.M.S.

MAJOR-GENERAL H. HENDLEY, K.H.S., I.M.S.

THE HON'BLE MAJOR-GENERAL G. G. GIFFARD,
C.S.I., I.M.S.

and, as co-opted members SIR T. NARIMAN, Kt., and LIEUTENANT-COLONEL BHOLA NAUTH, C.I.E., I.M.S.

LIEUTENANT-COLONEL A. SHAIRP, C.M.G., Indian
Army.MAJOR M. T. CRAMER-ROBERTS, D.S.O., Indian
Army.MAJOR A. A. MCNEIGHT, I.M.S. (*Secretary*).DR. M. R. GURUSWAMY MUDALIYAR, B.A., M.B., C.M., Acting Second Physician, Government General Hospital,
Madras.*Written statement.**General.*

After the perusal of the schemes furnished with Madras Government letter no. 543-2 (Medical), dated 20th February 1919, I have the honour to submit that one is forced to the conclusion that it cannot but be unsatisfactory to the civil assistant surgeons.

After the readiness with which they responded to the call of the Empire, and the creditable way in which they have acquitted themselves, as admitted in the various annual administrative reports, I have to confess that the civil assistant surgeons are taken by surprise when they are practically asked to acquiesce in an arrangement which, if given effect to, will, in their opinion, blast their prospects. Now that the usual plea of incapacity for administrative work and the racial unfitness for martial work was thoroughly disproved by accomplished facts, their hopes to go unfulfilled and their prayers unanswered is certain to cause wide-spread discontent among this class of useful workers.

The schemes that have been put forward emphasize racial differences, run counter to the promises and hopes held out by the Royal Public Services Commission and Montagu-Chelmsford schemes and are so obviously one-sided that I feel with great regret my inability to accept any of the schemes A, B, C or D.

Hence I have the honour, if my evidence is required, (I speak as representing the considered opinion of the Madras Medical Association) to say that the scheme submitted herewith as a fifth alternative might be considered with a view to see how far it will meet the requirements of the various parties as they stand at present.

In devising such a scheme for submission I have been naturally handicapped by the fact that my knowledge of military requirements and organization is imperfect and so I do not presume to go into the details of the military portion of the medical service. One point, I have to observe, however, and that is, the response the present war evoked from the medical men of this country goes, in my opinion, to prove as nothing else can, the wastefulness of maintaining a war reserve on the present lines (if it has to be in any way adequate at all), and the easy possibility of maintaining a sort of practical inexhaustible special reserve (or medical militia if one may so call it) at a minimum cost. I leave, therefore, the question of unification or otherwise of Royal Army Medical Corps and Indian Medical Service to competent military authorities, craving permission, however, to point out that more consideration must be shown to the aspirations of the civil assistant surgeon.

The scheme I put forward is as follows:—

The medical service in India may be divided into military and civil—a portion of the military being allowed to the benefits of civil posts and all the civil men being compulsorily trained initially and periodically for military medical work and kept as a special war reserve.

The military portion may consist as at present of Royal Army Medical Corps and Indian Medical Service and if they unite they form Indian Military Medical Service.

Indian Military Medical Service (I.M.M.S.).

Superior grade—

- (i) Royal Army Medical Corps (for British troops).
- (ii) Indian Medical Service (for Indian troops).

Subordinate personnel as at present.

Recruitment—

Royal Army Medical Corps—as at present.

Indian Medical Service—by an open competitive examination held simultaneously in England and in India and thrown open to all His Majesty's subjects who possess a British-registrable qualification.

Training.—All officers to undergo initial military medical training at the military medical colleges in England.

Conditions of civil employment.—Officers of not less than five years' standing should be eligible for transfer to the civil, 50 per cent. of the superior civil posts being reserved for these.

The military officers so transferred to the civil should be given periodic military medical training.

Indian Civil Medical Service (I.C.M.S.).

Class I consisting of—

- (a) Military officers lent to civil—50 per cent. of this class being filled by these.
- (b) Officers permanently promoted from class II.

Class II consisting of—

- (a) Civil assistant surgeons.
- (b) Promoted civil sub-assistant surgeons who will form a definite percentage of this class.

Officers of class II will be eligible for promotion to class I after 14 years' service, for merit, in the case of those who begin as civil assistant surgeons; and in the case of promoted civil sub-assistant surgeons after a total service of 20 years.

13 March 1919.]

Dr. M. R. GURUSWAMY MUDALIYAR.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

Recruitment of civil assistant surgeons—as at present by open competition.

Class III composed of the class that is at present called sub-assistant surgeons, recruited “for the time being” as at present, *i.e.*, without competition.

It is time that the standard of education for this class of officers is so improved as to bring it on a par with the licentiates of England. Under such improved conditions the diploma holders and the graduates of our universities might be allowed to compete on equal terms for all grades of the civil medical service.

Conditions of service.—It must be made a condition of Government service that all men that enter it must undergo military training both initial and periodic and hold themselves liable to military duty when occasion arises. When so drafted temporarily into the military, officers of class I should be given a military rank corresponding to their period of service and officers of class II should be given a commission of a lieutenantcy at least.

Specialists.—Professorial appointments, chemical examiner, bacteriologist, pathologist, alienist and other specialist appointments should be recruited for from the medical profession at large. Men in service, whether military or civil, should not be ineligible for these appointments; and if chosen should cease to be counted in the general cadre. These men should be free from liability to be called upon to serve in the military. The salaries of these should be large enough to induce the best men to covet these appointments.

Study leave.—All classes of officers should be required to take one year's study leave in the course of their service.

Pension.—Men in the Indian civil medical service should be allowed to retire optionally on full pension after 25 years' service or on medical certificate after 20 years' service.

Questions for witnesses.

1. Defects of Royal Army Medical Corps. I do not know.

About the Indian Medical Service in India the drawbacks I have noticed are—

(i) The reversion of these officers to military after they have served continuously in the civil for a number of years is prejudicial to the interests of both civil and military department. The civil side loses the benefit of the ripe experience of these officers, while the military side receives men, who can, in the nature of things, be but inefficient for military administration.

(ii) The present practice of making the professorial and other special appointments a special reserve for Indian Medical Service officers limits considerably the field for choice of men best suited for these posts and hence often results in unsatisfactory selections being made.

The scheme which I have suggested with a view to remedying existing defects, commends itself to me, for I believe it meets the present requirements better than any other scheme.

2. Yes, I do think it will meet the needs of the army in India and deserves to be approved by the War Office.

3. I think so.

4. The result of withdrawing European medical officers from charge of civil districts has been (so far as my information goes) beneficial to the civil assistant surgeons who got a chance of working on their own initiative, and has been more popular with the masses as seen from the larger number of cases treated. By the latter remark I do not mean to say that the European officers have been unpopular, but the Indian patient feels much more at his ease with an Indian officer and expects greater sympathy and acquaintance of social customs and manners from him than he does from a European officer.

Yes, my scheme will meet the civil needs and is less liable to break down during a war on a large scale.

6. Yes, it gives a very good reserve. If it is not enough, I would suggest the application of India Defence Act and require all medical men to compulsorily join the military.

8. I have no information.

9. *Vide* my scheme.

10. *Vide* my scheme.

11. Promising candidates might be sent out on Government scholarships to selected research laboratories in Europe and on their return asked to continue their investigations in separate research laboratories to be started, or in the existing institutes. They should have an adequate salary and not allowed private practice.

12. In the Presidency town, I do not think the practice of the Indian Medical Service officers has suffered. It has been as before. But in the mufassil as a class Indian Medical Service officers are losing ground. This is mainly due to the fact that larger numbers of efficient local graduates are being turned out, who are steadily absorbing more and more practice and are much cheaper than the Indian Medical Service officers.

Answers to questions for civil assistant surgeons.

1. Yes, I am prepared to serve with Indian troops and in Indian station hospitals on the conditions laid down in my scheme.

2. *Vide* scheme.

3. I do not see the bearing of the question.

4. Yes. At present military assistant surgeons, who are confessedly of a lower standard of general and professional education, when transferred to the civil are often put above the civil assistant surgeons. There are a number of places which are kept specially reserved for them, for reasons which are not obvious. This necessarily causes a good deal of dissatisfaction to men of my service. So far as civil surgeoncies and district charges are concerned, the assistant surgeons feel that no justice has been done to them.

5. Better prospects might attract even a better type of men.

6. None.

7. It will not be popular with men of my service—*vide* answer to question no. 4.

8. Certainly it will be popular. As a matter of fact we have prayed for this in our memorial, submitted so long ago as March 1918. A copy of the memorial that was submitted is attached herewith.

ENCLOSURE.

Memorial to His Excellency the Governor in Council (through the Hon'ble the Surgeon-General with the Government of Madras).

RESPECTFULLY SHEWETH,

1. The memorialist begs leave to approach Your Excellency's Government with the following representation in regard to the changes, now in contemplation consequent on the recommendations of the Royal Commission on the Public Services in India, and on the experience gained of the work of the medical services during the present war, in so far as they affect his position, prospects, pension, etc., as a member of the service.

2. *Pay.*—(a) The memorialist respectfully submits that the scale of pay fixed for the civil assistant surgeon is very low, considering the general educational standard prescribed and the length and difficulty of the professional courses that have to be undergone, and compares unfavourably with the emoluments of officers in corresponding grades in other departments of Government. Entrants to the medical service should have passed at least the intermediate examination of an university; and the medical course itself takes at least five years and is known to be very arduous. Most medical graduates, again, have to serve one year as house physicians and house surgeons before entering service which is by a competitive examination. The memorialist, therefore, submits that the present initial pay of Rs. 100 is inadequate. Gazetted officers of other departments start on a much higher salary and the memorialist respectfully submits that the initial salary of his service may be fixed at Rs. 250, and that, like these other officers, members of his service may, in the ordi-

18 March 1919.]

Dr. M. R. GURUSWAMY MUDALIYAR.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

nary course, be allowed to rise to Rs. 750. It is sometimes stated that in fixing the pay of medical officers the right of private practice they enjoy should be taken into consideration. The memorialist submits, however, that owing to the heavy work in hospitals, which are gaining in popularity every day, and the frequent transfers to which he is liable in the exigencies of service, he has no time to build up any private practice worth the name and that in competition with independent private practitioners who are permanent men with definite local influences and whose number is ever on the increase, he is at a very great disadvantage. For all these reasons the memorialist submits that the scale of pay of his service in the ordinary course be fixed at Rs. 250—25—750 (annual).

(b) *Civil surgeoncies and district charges.*—The memorialist submits that, at present, only six civil surgeoncies—all of them second class charges—are open to the 200 civil assistant surgeons in the service. Since the commencement of the war, for over three years, civil assistant surgeons have been holding first and second class district charges and other posts of equal responsibility, and the Government's review of the latest triennial report of the Surgeon-General with the Government of Madras (*vide* G. O. no. 406, dated 24th September 1917) would show that the efficiency of the department is being maintained at a satisfactory level. The memorialist therefore submits that not less than 50 per cent. of the district charges and civil surgeoncies may be held by members of his service, selection for these appointments being for merit after a minimum service of ten years; and that the salary of these posts may be fixed at Rs. 600—50—1,200 (annual).

DR. GURUSWAMY MUDALIYAR, called and examined.

(Mr. Hignell.) To a certain extent his scheme was an elaboration of the present arrangements. He would keep the Royal Army Medical Corps and Indian Medical Service for British and Indian troops respectively. In addition to these he would have a separate Indian civil medical service.

In class I of his scheme, he would reserve 50 per cent. of the posts for military officers who would be lent to civil. These posts would remain permanently reserved for them but the officers might keep changing. They should be in civil employ for only 5 years, after which they would not ordinarily return to civil again; but it would depend upon whether the civil or the military wanted them.

For the remaining 50 per cent. of the posts, recruitment should be made by an open competition held simultaneously in England and in India. He was aware of the practical difficulties in the way. In the theoretical examination, he did not anticipate any difficulty, and he did not think that such difficulties as might arise in connection with the practical examination, would be insuperable.

(General Hendley.) He thought that it was a waste to maintain the war reserve on its present lines. The reserve was quite inadequate and it did not serve the purpose for which it was intended. During the last 35 years, there had been only two calls on it and each time only less than 100 persons were called. In view of this, he thought that it was unnecessary that a large number of men should be kept in the reserve. If civil medical men could be turned into a war reserve, by giving them military training, the money spent on the maintenance of the present war reserve could be saved. A war reserve could be formed of civil assistant surgeons and independent medical private practitioners. But the private practitioners should be the last to be called. In fact he would go further and say that every medical man ought to have a military training and ought to be called upon to serve in the army if necessity arose. He did not think that compulsory military training would be unpopular either with the civil assistant surgeons or with private medical practitioners.

(Sir T. Nariman.) As regards the practical part of the simultaneous examination, the chief difficulty was in connection with the examiners. There would be two

(c) *Professorial and special appointments.*—Members of his service who have specialized in particular subjects may be declared eligible for the professorial and other special appointments and the pay of these may be fixed from Rs. 800 to Rs. 1,500.

3. *Other conditions of service.*—The memorialist humbly submits that his service may be styled the "Madras Medical Service" and that all the appointments, excepting professorial and special appointments, may be included in one cadre, so that a young recruit may look forward to rising up to the highest appointment in the service; and further that the recommendation of the Royal Public Services Commission in regard to (1) the abolition of the customary prefixing of the title "Civil Assistant Surgeon," (2) the abolition of septennial examinations, and (3) the giving of facilities for study leave, may be given effect to as early as possible.

4. *Pension.*—The memorialist submits that in view of the fact (1) that he works throughout his service without the usual holidays, i.e., about 85 days in the year, and (2) that he has to come frequently into contact with dangerous and infectious diseases, he may be permitted to retire optionally on full pension after 25 years' service or on medical certificate after 20 years' service.

5. *War reserve.*—In consideration of the fact that a large number of local medical graduates and civil assistant surgeons willingly offered their services for military duty during the present war, and being given temporary commissions have been doing their duty loyally under trying conditions, the memorialist submits that the service to which he belongs may be utilized as a war reserve, to effect which each member of his service may be given the necessary military training.

sets of examiners, one in India and the other in England.

The Public Services Commission had recommended that a purely Indian civil medical service should be established. In his opinion that was a good idea and it ought to have been taken up. Unfortunately the schemes outlined by the Committee did not contemplate any such civil medical service. So he thought that this Committee's schemes ran counter to the promises and hopes held out by the report of the Public Services Commission.

The education of the present sub-assistant surgeons should be so improved as to be on a par with the licentiates of England. Even if that was done, he did not think that it would be difficult to get men for the inferior service.

Recruitment for classes I and II would be by open competition. The numbers who had sufficient money, etc., to compete at the open examination would be limited; and of these numbers only a certain proportion would be successful. The remainder would enter the inferior service. The present system was not congenial to the growth of the independent medical profession at all. At present the sub-assistant surgeons were unreliable and they were not able to attend to an emergency case in the mufassil where they mostly were. What was required was to raise the standard of the qualifications of sub-assistant surgeons, and not to abolish this class altogether.

He had no information as to the effect of the withdrawal of British officers from the charge of troops and from jails. So far as civil districts went, the withdrawal had not been felt by the civil population.

If the Madras Government took away the civil surgeoncies from the hands of civil assistant surgeons, it would be very unpopular.

(Lieutenant-Colonel Bhola Nauth.) He was in Government service. The candidates selected for class I should go to England for their training for one year at the military medical college there. They might be there for about a year. Officers would be promoted from class II to class I after 14 years' service. These men need not go to England.

The Indians who entered the Indian Medical Service were high caste, well-to-do men. Six of them had gone from Madras and he knew all of them personally.

13 March 1919.]

Dr. M. R. GURUSWAMY MUDALIYAR.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

At present there was no restriction as to the caste of Indians competing for admission to the Indian Medical Service. If a low caste man got into the service, by the time he had returned from England, he would have improved in every respect. After all, it was only a question of training.

He would not put any limit to the number of Indians to be admitted into the services. Even if the whole service was manned by Indians, the British character of the administration would still be retained.

(General Hehir.) At present the maintenance of the war reserve was simply a waste. He did not object to paying as much as would attract really clever men for special appointments. The opinion of the general public was that India had to pay too dearly to get a few exceptional men, as, with the exceptional men, came a very large number of average men. The Indian civil medical service could be used as a war reserve. It would not affect recruiting even if military training were made compulsory.

He would select candidates for 50 per cent. of the posts in class I by an open competition. Afterwards, if necessary, a further selection might be made either by the Director General, Indian Medical Service, or any other responsible person or a board, after careful enquiries about the candidates' antecedents, etc., had been made.

He did not think that all the students of the various medical colleges in India would sit at the competitive examination that might be held. Only very few would

apply. So he did not anticipate any difficulty in the matter of selection.

The education of the sub-assistant surgeons ought to be improved as early as possible, as complaints were very often heard that the needs of the civil population were not met adequately. They should be made reliable by giving them a better education. He knew that the education of the sub-assistant surgeons was improving and he wanted it to be still further improved.

Military assistant surgeons would find a place in his scheme only if they were duly qualified and did not fall behind the civil assistant surgeons. In other words, they would have to stand on their own merits. No special privilege would be given them. At present the military assistant surgeons were given special privileges. These were about 46 civil surgeoncies open to total of 98 military assistant surgeons in civil employ; whereas only 32 such appointments were reserved for a total of 723 civil assistant surgeons.

Promising candidates should be sent out on Government scholarships for research in the famous laboratories of Europe. The principals of the various colleges could be requested to nominate proper candidates. There would be no objection to their being trained in the Indian research institutes at first.

Government officers employed in research work should not be allowed to do private practice. But they should be paid at a special rate to compensate them for this.

THE HON'BLE LIEUTENANT-COLONEL W. J. NIBLOCK, M.B., F.R.C.S., I.M.S., Officiating Surgeon-General with the Government of Madras, representing the Government of Madras.

Written statement.

The object of a medical service is the treatment of the sick, and in time of war of the wounded. So far as the Government are aware, a sick man receives or should receive the same medical treatment whether he is a soldier or not. Except therefore for non-medical reasons, there seems no reason why the soldier should be treated in a separate hospital from the non-soldier. Such a non-medical reason might be supplied by the exigencies of military discipline, but experience has shown that, so far as discipline is concerned, the soldier can be treated without objection in hospitals open to other classes of the community and the Government of Madras would, therefore, advocate the abandonment of special military hospitals and the adoption instead of the principle of general hospitals, open to military and non-military alike.

2. The objections to the system of separate military hospitals include the following :—

(1) *Waste of power.*—If a separate hospital has to be maintained for military patients wherever there is a detachment of troops, however small, a separate staff, separate equipment, separate buildings, and a complete separate organization are necessary, whereas, if the principle of treatment in a general hospital is accepted, this unnecessary duplication is avoided.

(2) *Loss of efficiency.*—If a medical officer is restricted to the treatment of military patients, his opportunities for medical practice are greatly restricted. As soldiers are necessarily men in early adult life and presumably in sound health on admission to the army, the amount of sickness amongst them is small and the medical officer whose duties are limited to dealing with this class of patient, has but a very narrow field of experience, even in the largest military centres, while those in charges of small military detachments are practically without an opportunity of keeping themselves efficient. On the other hand, a general hospital offers an unlimited field of experience. It is truism that medical science is progressive, and it

follows that wise and constant study and experience are necessary to keep a medical officer up-to-date.

3. If the principle of general hospitals is admitted, there should be a single medical service to deal with them, just as there should be one general hospital for soldiers and non-soldiers alike. The Government are not in favour of any scheme which tends to break up the medical service in India into two rival and jarring bodies, one civil and the other military. They advocate a truly unified service, such as the Government of India are apparently in favour of.

4. This medical service should be a service for India and India alone, with the possible addition of other connected regions such as Mesopotamia. While there is no rationale for providing a separate service for different classes of the population, there is sound reason for providing a separate service for India, as opposed to other portions of the Empire. The Government of Madras are opposed, in the interests alike of the military and civil population, to any scheme such as scheme A which seeks to man the medical service from a service common to the rest of the Empire. The result of such a scheme is to enable medical officers who are totally ignorant of Indian conditions to be placed in charge of hospitals in India without any preliminary training. The treatment of tropical disease demands experience in the tropics and forbids the acceptance of a scheme which might entrust the charge of a patient suffering from Asiatic cholera, plague or malaria to an officer who had never seen one of these diseases or had met them only as rarities under European conditions. On the other hand, it appears to His Excellency the Governor in Council that India is large enough to have a medical service of its own. Apart from the civil population of 350,000,000 it may have in the future an army of 500,000 men (British and Indian) and in the interests of that army as well as of the civil population, the Government of Madras advise the creation of a unified service for India.

5. In this unified service, which should be the Medical Service of India, due opportunity must be given for qualified Indians. The policy of gradually introducing Indians into all branches of the public service has been

13 March 1919.]

The Hon'ble Lieutenant-Colonel W. J. NIBLOCK.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

publicly adopted by the Secretary of State and the British Ministry, and the Madras Government are in favour of it. Nor is there any sufficient reason to believe that insuperable objections exist to the application of this policy to the medical service. His Excellency in Council is advised that experience proves that the British soldier is not unwilling to be treated by Indians and in any case it is a step the adoption of which the development of Indian administration renders inevitable.

6. In order to provide for the admission of qualified Indians, some form of simultaneous examination seems to be necessary as Indian candidates can no longer generally be required to proceed all the way to Europe on the chance of succeeding in a competitive examination there. His Excellency in Council accordingly advocates the adoption of a scheme of which the following would be the main outlines :—

- (1) A single medical service to be created for the whole of India, to provide for the treatment of the sick, both military and civil, in general hospitals.
- (2) For the present, seventy-five per cent. of the recruitment for this service to be made by competitive examination in England (to which Indians would be admitted) and twenty-five per cent. by competitive examination in India, all successful candidates selected in India to be required to proceed to England to undergo at least one year's further clinical training and study there, being granted the necessary allowance for the purpose.
- (3) The relative seniority of the candidates selected in England and India to be determined by a final examination in which the marks obtained during the year of further clinical training and study should be taken into account.
- (4) All members of the Medical Service of India to be given the same scale of pay, allowances, and pension, but those candidates whose home is in Europe to be allowed a special additional allowance to cover the additional expenses involved in service in a foreign country.
- (5) The terms of pay, allowances, and pension in the Medical Service of India to be so fixed as to ensure the securing of candidates of sufficient calibre and professional equipment.
- (6) All members of the Medical Service of India under twenty years' total service to be required at least twice to spend six months on medical study in Europe. During this time, they would be allowed two-thirds of their Indian pay provided they satisfy the Secretary of State that they have made satisfactory use of the time.
- (7) All hospitals to be general hospitals, i.e., available for the treatment of all male classes of the community, military and civil, and every general hospital to be under the control of an officer belonging to the Medical Service of India. Owing to the customs of the country, women and children would, as far as possible, be treated in separate general hospitals.
- (8) The Medical Service of India would be under the general control of a Director General and there would be a Surgeon-General under each local government as at present.
- (9) Under the Director General there would be two Assistant Directors General, one of whom would deal with civil medical administration and the other with military medical administration.
- (10) Under the control of the Assistant Director General for military medical administration, the existing medical organization for war purposes would be continued and improved so that in place of the present divided control which has caused so many evils in the recent war, there would be unified control. All

members of the Medical Service in India except holders of specified excepted posts, would be allotted their due position in that organization and should be required to spend three months after every five years in the study and practice of that organization. A special reserve of the Medical Service of India would be maintained for military organization, for special military purposes such as the medical charge of troops in camps of exercise, on the march, in rail transfer, etc. When not employed, this special reserve would be available for employment as supernumeraries in the Presidency hospitals. The medical charge of troops on the voyage to and from India to be provided for by the Royal Army Medical Corps, but the Royal Army Medical Corps would not otherwise contribute to the medical services of India, except as a temporary measure at the first introduction of the new Medical Service of India.

- (11) The number of members of the Medical Service of India to be made available for military duty in the case of war to be fixed with reference to the necessary minimum required for carrying on of the non-military duties of the country and the total strength of the Medical Service of India to be so raised as to provide an adequate medical reserve for military purposes in time of war. This will probably involve the withdrawal of civil surgeons from the provincial medical service and compensation for this loss to be made in fixing the terms of pay, etc., of the provincial medical service.
- (12) Below the Medical Service of India would come the provincial medical service. This would consist of an upper and lower division, the one composed of assistant surgeons and the other of sub-assistant surgeons. Officers in the lower division would be eligible for promotion into the upper division and officers of the upper division would be eligible for promotion to the Medical Service of India by special selection. The conditions regulating such special selection may be separately determined. The terms of pay, allowances, and pension of the provincial medical service should be revised so as to make them equally attractive with those of other provincial services.
- (13) In the case both of the Medical Service of India and the provincial medical service, private practice should be allowed except to the holders of a few specified appointments.
- (14) The present system of allowances to be as far as possible got rid of and replaced by consolidated rates of pay.

N.B.—The Hon'ble Mr. P. Rajagopala Achariyar dissents from so much of clause 6 (4) as relates to the grant of a special additional allowance to European members of the Medical Service of India.

Answers to questions forwarded with letter from the Secretary, Medical Services Committee, no. 11-12, dated 23rd February 1919.

Q. 1.—How would your Government view the compulsory military training of some portion of their civil assistant and civil sub-assistant surgeon cadres?

A.—His Excellency the Governor in Council would raise no objection to such a proposal, but it might possibly render it necessary to offer rather better terms in order to secure suitable recruitment.

Q. 1.—(a) Would your Government be contented to continue to give Indian Medical Service military officers all superior appointments, if the Government were permitted to choose outsiders themselves for special appointments when they wish to do so?

A.—The Government of Madras have stated their views as to the recruitment of the Medical Service of India in a detailed note. Provided that the proposals in

13 March 1919.]

The Hon'ble Lieutenant-Colonel W. J. NIBLOCK.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

that note are accepted, they would not object to the suggestion now put forward.

Q. 2.—How do Government view the question of the increase of officers in superior appointments in civil cadre (1) from the Indian Medical Service, (2) from outsiders?

A.—The vagueness of this question makes it difficult to offer any satisfactory reply. Considerable increase in the cadre of the medical service of India will be necessary, and if that increase is made on the lines proposed in this Government's note on the general re-organization question, His Excellency the Governor in Council does not contemplate enlistment of outsiders except for special appointments requiring special qualifications.

Q. 3.—Are they prepared to make it a condition of appointing an outsider that the officer should belong to the second reserve?

A.—As already stated, the Government do not contemplate the enlistment of outsiders except for appointments requiring special qualifications. For such appointments, it would probably be undesirable to require that the officer so recruited should belong to any military reserve as he would presumably be a specialist who should be retained at his special duty.

Q. 3.—(a) Are they prepared to make it compulsory if he is an Indian?

A.—See answer to question 3 above. The fact that the officer being an Indian does not affect the conclusion stated.

Q. 3.—(b) Does Government consider that military medical officers are *ipso facto* better in the superior appointments than pure civilian doctors?

A.—The Government are not prepared to lay down any such generalisation.

Q. 4.—In view of what has happened during this war in the admitted failure of Indian practitioners of standing and of senior civil assistant surgeons to come forward to form an army medical reserve, does Government consider that in the future a reserve could be formed from the independent profession on reasonable terms?

A.—No.

Q. 5.—Have Government found that the present leave reserve in civil employ is numerically sufficient to ensure that medical officers get all the leave which is due to them under the Civil Service Regulations and also the study leave?

A.—Experience has proved beyond doubt that the existing medical leave reserve is entirely inadequate for the purposes mentioned.

Q. 6.—What do you think of the idea of giving free treatment to the families of all civil officers in the outlying districts of the province?

Q. 7.—What do you think of giving free hospital treatment in selected centres to the families of all the officers in the various civil services?

A.—The proposal here made would in effect be an addition to the salary of the civil officers referred to and the Governor in Council is disposed to think that such an addition should preferably take the form of an increase of pay rather than of an added privilege given at the expense of the officers of the Indian Medical Service. It is evident that the grant of free attendance to families would considerably restrict the opportunities of private practice and on the whole His Excellency in Council is not in favour of the idea.

THE HON'BLE LIEUTENANT-COLONEL W. J. NIBLOCK, I.M.S., called and examined.

(Mr. Hignell.) In order to prevent any idea that candidates who passed the examination held in India were inferior to those who passed in England, a final examination should be held in England for all candidates and the result of this should fix the relative position of officers in each batch.

The Government of Madras would prefer that an entrance examination for the 25 per cent. of the vacancies being reserved for Indians should be held in India. The examinations in India and England would not be necessarily simultaneous.

The Government of Madras suggested the extra allowance for officers whose homes are in Europe on the

Q. 8.—Would you be in favour of appointing two or more travelling consultants and travelling experts in the Province?

A.—No. The need for such consultants and experts has not hitherto been prominently brought to the attention of this Government.

Q. 9.—In order to meet the requirements of the army medical officer, it is considered necessary that long periods of civil employ, without the connection with the army, should cease, and that all military medical officers in civil employ should return to the army for periodical periods of service and military training. Would your Government be prepared to allow the Indian Medical Service officers in civil employ (except those in residuary or indispensable appointments) to return for one year at the end of each five years to the army? Do you consider that such a return to army employment would dislocate civil work to such an extent as to render such a scheme unacceptable?

A.—Reference is invited to the note of this Government on the general question of military reorganization. His Excellency in Council considers that a period of three months' training in military organization at the end of every five years would suffice.

Q. 10.—How would you arrange in your province to meet the legitimate aspirations of Indian graduates towards a larger share in the superior civil and superior medical educational appointments with the constantly expressed desire of the European officers of the civil service that they and their families might be in a position to always obtain in all parts of the district the services of the European doctor.

A.—In view of the necessity of admitting Indians to the medical service of India, a point which has been dealt with in paragraph 7 of this Government's note on the general medical reorganization His Excellency in Council considers that it is impossible to secure the services of a European doctor in all parts of the country for families of European officers. European officers who elect to serve the Government in India will have to accommodate themselves to the changed political situation of the country.

Q. 11.—Has there been in your province any failing in the quantity or in the quality of the civil medical work done since the Indian Medical Service officers were recalled to military duty and their civil duties handed over largely to civil assistant surgeons?

A.—His Excellency in Council does not think that it would be desirable to make a general reply either affirmative or negative to this question. He is advised that, while a certain number of the assistant surgeons employed in posts generally held by officers of the Indian Medical Service have shown themselves equal to that position and have done work which is not below the quality of the work ordinarily turned out by the Indian Medical Service, a larger number have failed to maintain the same standard of efficiency as is ordinarily expected from the Indian Medical Service. The failure of the assistant surgeon class has naturally been more prominent in those cases where he has been called upon to deal with and manage a considerable staff of European nurses or otherwise.

assumption that some form of expatriation allowance would soon be introduced for all Government services.

He did not foresee any difficulty in admitting civil patients into the large military station hospitals such as in Bangalore or Secunderabad.

He had said in his written statement that Indians selected in this country should be given a year's practical training in England, but that was suggested as a bare minimum. It would undoubtedly be better if they were given two years instead of one.

He approved of the proposal to establish an Indian Military Medical Staff College, but the existence of such a college in India would not do away with the necessity for study leave or "duty" to England.

13 March 1919.]

The Hon'ble Lieutenant-Colonel W. J. NIBLOCK.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

He had first recommended that officers in civil employ should have six months' military training every five years, but discussion of this point with officers who had lately returned from military duty had convinced him that three months would be sufficient.

The specialists he was referring to in his answer to question 3, would be classed as holders of residuary appointments. If this was done, they would not belong to any military reserve.

He said that "study leave" should be treated as duty, and called "study duty," in order that it might not be mixed up with other kinds of leave. The leave reserve was not at all sufficient.

(Lieutenant-Colonel Bhola Nauth.) He did not think that any complications would arise if civilian and military patients were treated in a combined hospital. In the case of large military hospitals, they would be entirely under military officers. On the other hand the management of smaller hospitals would be in the hands of a civil surgeon; but equipment, clothing, etc., would be in the hands of military officers.

The civilian patients would not be inconvenienced by being treated along with military men. They need not be put under the same hard and fast rules. They should be treated as human beings when they came to hospitals for treatment. After all it was the disease that required treatment.

Even if a staff college was established there would still be necessity for "study duty." A staff college was intended to train officers for military duty; whereas study duty was intended for medical men to improve their professional knowledge by going to Europe for medical study.

He did not think that the holding of a simultaneous examination in India would open the door wider for low-caste Indians to get into the medical service. On the contrary, he thought that a higher class of men would enter. At present the best class of students entered the legal profession; others took up teaching or joined the telegraph department, etc., where they were better paid; while those who went in for medicine, in which pros-

pects were not good, were generally speaking from a lower class. If a simultaneous examination was held in India and 25 per cent. of the vacancies in the new service were reserved for those who competed at this examination, a better class of men would enter the service as the prospects of Indians in it would be better than at present, owing to the proportion of Indians being so much larger. Personally he would prefer to select candidates for some years to come by nomination instead of by open competition to ensure that they were all responsible men.

(Major Cramer Roberts.) In paragraph 6 (2) of his written statement it was recommended that officers proceeding to Europe for medical study should be given two-thirds of their pay; this proportion was suggested as there seemed to be no probability that Government would sanction anything higher.

(Sir T. Nariman.) He thought that only caste persons, i.e., persons having caste prejudices like Brahmins might object to being treated in a joint hospital. But non-caste men would not object. They only wanted proper treatment, and if the treatment was good, they would not say anything.

If Madras Government's scheme was sanctioned he was confident that a good type of men would be attracted to the service.

If the war reserve of the Indian Medical Service were increased and the Government of Madras were asked to take a larger number of Indian Medical Service officers on to their strength, they could easily do so. Additional officers could with great advantage be employed in the medical schools and colleges and in specialist and sanitary appointments. There would not be any great increase in the number of civil surgeoncies reserved for commissioned officers.

Some years ago the Government of India appointed an officer to be in sole administrative charge of the Medical College. The experiment was not a success. If the Principal was given the rank of a colonel, it might succeed. Otherwise keen officers would not take the appointment as it meant giving up active professional work.

DR. T. T. THOMSON, M.B., C.H.B., (Edin.), Medical Officer in charge of the London Mission Hospital, Jammalamadugu.

Written statement.

Answers to questions for witnesses.

Q. 1.—*Defects I have noticed.*—(a) I consider the war reserve was insufficient.

(b) As far as I have been able to judge I do not think Royal Army Medical Corps officers get sufficient experience in general medicine and surgery and are apt thereby to get "rusty" in matters medical.

I would suggest that, where possible and advisable, civil hospitals should adjoin military hospitals, or in smaller military stations that military blocks be attached to civil hospitals, so that officers of the Royal Army Medical Corps or of any unified medical service would have more opportunity of all-round experience.

(c) I consider it a defect in the Indian Medical Service that a medical officer may remain for many years in civil employ without any systematic military medical training or without military experience but be suddenly called up on mobilization.

Of the attached schemes I consider a combination of C and B most likely to remedy existing defects.

I agree with the author of scheme C that reorganization rather than unification of the medical services in India is the necessary and feasible course to be adopted at the present time.

Schemes C and B commend themselves to me for the following reasons:—

(a) there would be a sufficient and efficient reserve for military purposes;

(b) there should result increased efficiency of Royal Army Medical Corps officers in matters medical and surgical;

(c) there should result increased efficiency of Indian Medical Service officers in matters military.

Although supporting a scheme of reconstruction of the medical services for the present time and needs, I can foresee that it may be advisable in the future to effect a complete fusion of the military branch of the Indian Medical Service with the Royal Army Medical Corps and the establishment of a civil Indian medical service. In that eventuality it would seem to me to be a necessity to form this civil Indian medical service into a reserve for military purposes, bearing in mind the special and peculiar conditions and needs of India.

There is plenty of need and room in India for all the British and Indian medical men and women, it is likely to get for years to come.

India, in its aspiration for self-government, still needs a "lead" in the medical world as in other domains.

With the present reconstruction, it would be well to have 25 per cent. of Indians in the medical services of India.

I agree with the authors of schemes B and C that a special reserve of officers be formed from the British, Anglo-Indian and Indian medical practitioners and civil assistant surgeons in India.

Speaking of myself and on behalf of some other British medical missionaries in South India, we would be willing to be included in such a reserve, provided that the sanction of our Mission Boards at Home were received.

13 March 1919.]

Dr. T. T. THOMSON.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

I am in full accord with what the author of scheme B writes about :—

- (1) Medical Staff College in India (paragraph 19).
- (2) Provision for the treatment of women and children (paragraph 22).
- (3) Importance of growth of independent medical profession (paragraph 21).
- Private practitioners taking a part-time share in work which is now in the hands of Government services (paragraph 1).
- (4) Scholarships for Indian and domiciled community students to complete their education and social training in the United Kingdom (paragraph 6).
- (5) The importance of language examinations (paragraph 10).

I consider the acquisition of the language of the area of allotment so important, in order to gain the confidence of the Indian people and have more intelligent control of the details of the work, that it should be made obligatory on all officers in civil Government employ.

Medical officers in the Indian army need only be required to pass an examination in Hindustani, and may be called to serve in any part of India. Civil Government medical officers, however, in peace time, if they have a knowledge of the language of a certain area should be allotted to that area.

In war time they would, of course, be available for service anywhere.

In addition to the subjects already considered I am in full accord with the author of scheme C in the following :—

- (1) Improving the conditions of service of the military assistant surgeon and sub-assistant surgeon classes (paragraphs 27 and 28).
- (2) Employment of more specialists and consultants (paragraphs 37 and 38).
- (3) The organization of the civil medical services of India (paragraphs 41 and 42), except that [*vide* paragraph 48 (*iv*)] I would suggest placing the civil sub-assistant surgeons and military sub-assistant surgeons as (c) and (d) in "the lower grades," instead of in a "subordinate branch."

Q. 2.—As far as I know, I consider that what I have commended above will meet the needs of the army in India.

Q. 3.—Yes.

DR. T. T. THOMSON, called and examined.

(Mr. Hignell.) He was more in favour of improving the present conditions of the medical services in India than of making any radical change in their organization.

If 25 per cent. of appointments of any service were reserved for one particular nationality difficulties might arise. First of all there might be vacancies in any one examination, or examinations spread over one or two years, occurring only in the European side of the service in which case there would be no vacancy at examinations for Indians, and during that period very good Indians might fail to obtain admission into the service. On the other hand, if at an examination 25 per cent. of the places have been reserved for Indians, one might find, when the service became popular, that the Europeans who failed to get in were better men than the Indians who got in by obtaining the 25 per cent. reserved appointments.

The witness would, in the first instance, make his selection for the 25 per cent. of appointments reserved for Indians from among men trained in England. If the examination in England did not produce a sufficient proportion of Indians in the service then he would advocate examinations being held also in India.

The following would probably make the service more attractive to Indian recruits and Indian professional opinion :—

- (a) A synchronous examination in England and India for entrance into the Indian Medical Service. I am doubtful of the feasibility of introducing this, especially as candidates should study for a time in the United Kingdom before appearing for the examination.
- (b) The establishment of a civil Indian medical service.
- (For my remarks on this subject please see above in answer to question 1.)

Q. 5.—I think it will meet the needs of the civil administration in India.

Q. 6.—Yes. There would be a large reserve at once available for military purposes.

Q. 7.—Yes, there should be a medical service reserve for war previously trained in military work.

The major portion should be always actually present in India.

Q. 9.—The entrance examinations as now for Indian Medical Service and Royal Army Medical Corps with training at the Royal Army Medical College at Millbank for those officers at Home and at a similar college to be established in India for those out here.

Q. 10.—Special leave for study may be given, in the United Kingdom or in India, before the taking up of a special civil Government post or for examinations in connection with promotions.

Q. 11.—I suggest a special department for research may be provided in connection with the School of Tropical Medicine in Calcutta.

Answers to special questions.

Q. 1.—If Europeans in India as a whole are taken into consideration, as far as my experience goes, I should say that their demands for European medical attendance are based more on the comparative professional merits of the doctors rather than on purely racial predilection. An important exception is in the cases of women and children and especially in matters obstetrical and gynaecological. I agree with the author of scheme B with regard to provision for the treatment of women and children (paragraph 22).

In the case of some European patients I have known their objection to treatment by doctors educated partly or entirely in India to be based on doubt as to their "surgical" cleanliness.

Q. 3.—As far as my observation goes, I consider Indian medical officers of all grades have improved in efficiency in recent years.

(General Hendley.) There were in all about 320 members, including women doctors in the Medical Missionary Association of India. There were perhaps a few more medical missionaries who had not yet joined the association.

The witness was unable to say how many medical missionaries went on field service but he referred the Committee to an article headed "Medical Missionaries and the War" to be found in the Quarterly Journal of the Medical Missionary Association of India for January 1919, wherein the information was supplied. The witness handed in a copy of this journal for the use of the Committee.

He did not think his society would object to periodical military training of medical missionaries provided they were not put to inconvenience for any considerable length of time. For this military training he suggested a period of one month every other year.

Before the late war his society generally obtained drugs from England. Tinctures only were obtained from the Government medical stores. But during the war owing to the difficulty in getting out things they had obtained their supplies from the Government medical

13 March 1919.]

Dr. T. T. THOMSON.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

stores. In the future his society would like to obtain their supplies from the medical stores, provided they were charged according to category II—Charitable Institutions. His society had recently sent round a circular informing them that they were purchasing medical stores for the society from hospitals which were being disbanded in England, and asking them to put in indents.

For subordinates the society employed young Christians, whom they had educated themselves. These subordinates had been trained for 4½ years by the society's own staff, and after their training they were sent up to pass an examination held in Madras by the Government. They were permitted to sit for the final examination of sub-assistant surgeons in Madras and they all passed. The training of these subordinates had been stopped as they had not the staff to hold a class every year. They had only held two classes—one from 1905 to 1909 and

the other from 1910 to 1914. The society could not afford to send their men to Madras for training, and therefore trained them themselves.

(Lieutenant-Colonel Bhola Nauth.) He had put it at 25 per cent. to encourage Indians. He had no special reason for fixing the proportion of Indians to be admitted to the new service at 25 per cent. He thought that this figure would encourage Indians.

(General Hehir.) He advocated periodical military training for officers in civil employ in order to keep them in touch with military affairs.

The arrangement for recruitment for the civil Indian medical service should be that laid down in scheme C.

Officers of the civil Indian medical services should pass an examination in the language of the province to which they were posted.

THE HON'BLE DIWAN BAHADUR A. SUBBARAYALU REDDI GARU, B.A., B.L., Cuddalore.

Written statement.

I have studied the four schemes A, B, C and D as carefully as a layman unacquainted with the details of the medical services—military and civil—could do. I must frankly state that I absolutely disown all acquaintance with the condition, wants and requirements of the Indian military medical service. The little that I know of the Indian civil medical service is indeed very meagre, for want of opportunities to learn and to know more. The knowledge of that little I feel bound to take stock of, for the present, in order to enable me to appear before the Committee, of course, with diffidence.

2. Ordinarily, it is reasonable to think that the two services—military and civil—should be treated as separate departments, one not interdependent on the other. But a matter of fact they have been treated as one department. The service was organized and treated as military. When there was no war, when their services could be spared during peace, the officers were lent to the Government of India for performance of civil duties.

3. When, however, these duties were undertaken in course of time by the natives of the country, with almost equal efficiency, the Madras Government in 1899 and the Bombay Government in 1903 asked the Government of India for a separate civil and medical service, the Madras Government quoting as its reason "that among the defects of the system (of reserving all high grade civil appointments for members of the military service only), must be recognized a want of stability, a want of strict identification with the interests of the natives of the country, an exclusiveness which renders it difficult to introduce the natives of the country to the higher employments of the service;" comparing the system followed in the Arts, the Law and the Engineering faculties, the Madras Government said "To the scholars of these institutions all the highest appointments in the faculties are open. The professors of these schools are drawn direct from Oxford, Cambridge or London or are Indian graduates, and when natives are found equally competent and equally qualified, they are appointed to these places without any distinction of being members or not, of any particular service." The Government of Bengal urged "that the local medical service should no longer be primarily military, its chief function being now civil." The Government of India, however, declined to take up this question manifestly on grounds of policy and expense. The Royal Commission on the Public Services in India reiterated and accentuated this view of the Madras and Bombay Governments later on in the report they submitted. But before the report could be considered, the long and heavy war raged for over four years with the result that the opinions of the Governments and the Commission had to undergo revision; for, during the war, not only was the civil medical service mostly denuded of the Indian Medical Service officers both in the city and in the mufassils, but a number of dispensaries had to be kept closed as the subordinate medical officers in charge had to be sent for service in the battle-fronts.

4. In this state of things, a need certainly has arisen to enlarge the number of officers by adding to its medical staff, which must, in its turn, entail a large number of officers in civil employ. Now, the true question to be solved will probably be how many of these latter officers are to belong to the Indian Medical Service, and how many to the subordinate medical service, otherwise known as provincial medical service. I venture to think that this is the true question for solution by the Committee; for, Surgeon-General after Surgeon-General has recently reported about the efficiency of work done by the civil surgeons in charge during the war. The Madras Government has said: "The most noticeable point in the Surgeon-General's report is the increase in the amount of work done in spite of the depletion of the staff of all ranks. Less than a third of the ordinary establishment of Indian Medical Service officers remain in civil employment . . . The number of patients treated and the number of operations performed have been larger than ever before, while the death rate has been lowered." The Surgeon-General of Bengal has reported: "I am glad to say that all these officers have worked conscientiously and discharged their duties of appointments in an efficient manner, and that as far as can be judged from the result of the past year's work, the popularity and usefulness of the medical institutions have not materially suffered under the altered arrangements." It is, in my opinion, rather a difficult question for the Committee to solve or the Government of India to decide—what will be the relative strength of the Indian Medical Service officers to be placed in civil employ to that of the civil surgeons.

5. In this connection, I may invite the attention of the Committee to the observations of the Secretary of State and the Viceroy at paragraphs 315 to 318 of the report on Indian Councils Reforms:—

"(315) Subject to these governing conditions we will now put forward certain principles on which we suggest that the action to be now taken should be based. First, we would remove from the regulations the few remaining distinctions that are based on race, and would make appointments to all branches of the public service without racial discrimination.

(316) Next we consider that for all the public services, for which there is recruitment in England open to Europeans and Indians alike, there must be a system of appointment in India. It is obvious that we cannot rely on the present method of recruitment in England to supply a sufficiency of Indian candidates. That system must be supplemented in some way or other: and we propose to supplement it by fixing a definite percentage of recruitment to be made in India. This seems to be the only practical method of obtaining the increased Indian element in the services which we desire. We do not suggest that it will be possible to dispense with training in Europe for some of the principal services. It will be necessary to make arrangements to send for

13 March 1919.]

A. SUBBARAYALU REDDI GARU.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

training in England the candidates selected in India, but as to this we anticipate no difficulty.

(317) We have not been able to examine the question of the percentage of recruitment to be made in India for any service other than the Indian Civil Service. The commission recommended that 25 per cent. of the superior posts of that service should be recruited for in India. We consider that changed conditions warrant some increase in that proportion, and we suggest that 33 per cent. of the superior posts should be recruited for in India, and that this percentage should be increased by $1\frac{1}{2}$ per cent. annually until the periodic commission is appointed which will re-examine the whole subject. We prefer this proposal to the possible alternative of fixing a somewhat higher percentage at once and of making no increase to it until the periodic commission which we propose has reported. We cannot, at present, foresee the reorganization that may take place in the Indian Civil Service as a result of new conditions. For this reason we think it unwise to aim at attaining any definite percentages after a specified time. We prefer to fix a percentage applicable to present conditions and to commit ourselves only to a growing proportion, which will be subject to reconsideration and revision by the commission.

We have dealt only with the Indian Civil Service, but our intention is that there should be in all other services now recruited from England a fixed percentage of recruitment in India increasing annually. The percentage will not be uniform for all services as the particular figures must depend upon their distinctive characters and functions.

(318) The restriction of the number of Europeans in the services and the constitutional changes taken together will make it absolutely necessary for India to secure the very best type of European officers that she can get. We are, therefore, anxious that the present opportunity should be taken to do something towards restoring the real pay of the existing services to the level which proved attractive twenty years ago. We recognize and we regret that the improvement of the conditions of the European services in India has encountered opposition from Indians. We hope and believe that if proposals for such improvement are accompanied by increased opportunities being given to Indians in the services this opposition will cease. But in any case we feel that it is necessary to do something substantial in order to improve the conditions of service and to secure the European recruitment which we regard as essential."

6. I particularly lay stress upon paragraph 318; for, there the distinguished authors of the report emphasize the need for India of the best type of European officers that she can get, the need for their being paid an attractive pay and the need also for the Indian officers desisting from opposition to the just demands of the European officers. I understand that at present there are only six places thrown open to civil assistant surgeons when no commissioned medical officer is available. The Committee may exercise its discretion in enhancing this number and removing this condition. I need hardly add that I make it a condition precedent to such a promotion that the civil assistant surgeons qualify themselves for military service and belong to the war reserve. I would, in fact, insist on every medical officer of the provincial civil service qualifying himself for the war reserve as a condition precedent to his entertainment.

THE HON'BLE DIWAN BAHADUR A. SUBBARAYALU REDDI GARU, called and examined.

(Mr. Hignell.) He considered it a real grievance to the civil assistant surgeon class that military assistant surgeons should be placed in positions for which most of them were professionally unfit.

He was in favour of scheme B with the modifications suggested in his written statement.

(General Giffard.) He did not think that the whole private medical profession could be depended upon to help Government in case of need. A selection should be made from among private medical practitioners if Government required help.

There cannot be the least doubt that such a qualification is expected of any Indian medical officer, it being understood that he will get a suitable rank and pay for securing such qualification.

7. Assuming that there is the sentimental objection based on the race of the medical officer regarding the treatment of women and children referred to at paragraph 22 of the scheme B before the Committee, it seems to me that that objection is bound to vanish when lady doctors become available for their treatment.

8. I have but one word more to add. I believe that it is a real grievance to the civil assistant surgeon class that the class known as the military assistant surgeons should be placed in charge of offices and work for which, as a rule, most of them are unfit. The civil assistant surgeons are, as a rule, medical graduates turned out of an Indian medical college deservedly recognized as capable institutions in charge mostly of the Indian Medical Service officers. But what are the qualifications of the military assistant surgeons? The Public Services Commission said regarding them: "It is an unsatisfactory feature of the present arrangement that there are still districts in the charge of officers who would not be allowed to practice in Great Britain, and we trust that this will become increasingly infrequent." I understand, however, that it is in contemplation to get this class better equipped and to train them better than now.

9. In the light of the foregoing remarks, I proceed to submit my answers to the appended questions.

Q. 1.—What defects have you noticed in the organization of the Royal Army Medical Corps and the Indian Medical Services in India? Does any one of the attached schemes, which are suggested with a view to remedying existing defects, commend itself to you, and if so, which and why?

A.—Of the attached schemes, I prefer scheme B with the modification above referred to that the provincial civil medical service be given greater opportunities for being useful in the civil service by being made to undergo the necessary military training.

Q. 3.—Do you consider that the scheme which you prefer will attract a good stamp of recruits and meet the demands of professional opinion in England and in India? If the scheme which you prefer fails in either respect, how would you remedy such failure?

A.—I do consider that the scheme as modified above will attract a good stamp of recruits in India.

Q. 5.—Will the scheme which you recommend meet the needs of the civil administration in India? To what extent would it be affected by needs occasioned by war on a large scale?

A.—The scheme as modified above will meet the needs of the civil administration in India. I cannot answer the rest of the question.

Q. 9.—What system of recruitment and education do you recommend as desirable for medical officers in connection with the scheme which you prefer?

Q. 10.—Have you any suggestion to make as to the grant of special leave for study or as to prescribing periods of study?

A.—I cannot undertake to answer these questions.

Q. 11.—Have you any suggestions to make as regards the provision of a special department for research?

A.—All that I can say under this head is that there is an absolute need for a special department for research in India. This needs the employment of specially qualified men with suitable pay and emoluments.

He would not favour the idea of giving private practitioners charge of dispensaries and small hospitals, as he could not reckon upon subordinates.

If Government were prepared to spend more money in training medical men there would be no difficulty in supplying the civil needs of India.

He would make it a condition that the assistant surgeon must undertake a course of military training. If assistant surgeons wanted promotion they must undergo military training.

13 March 1919.]

The Hon'ble Sir F. E. BARBER.

(The schemes and questions referred to by witnesses are contained in Volume III.)

THE HON'BLE SIR F. E. BARBER, United Planters' Association of Southern India.

Written statement.

With reference to the possibility of unofficial medical practitioners taking a place in future in the official medical organization of India, both in peace and war.

It might possibly be a useful step if unofficial medical practitioners take a place in the official medical organization of the country, but I cannot see that it would help matters if individuals are taken on in this way. I can imagine a practitioner coming out to this country and settling in some centre to work up a remunerative practice, but I do not think, having done so he would be willing to put himself under official restraint except at a time of national emergency.

On the other hand, organizations bring out doctors on specified terms of service and I think that it is quite possible that such individuals might take a place in the official organization of the country.

Probably no European community in India is so ill-equipped in regard to medical assistance as is ours, yet few can have greater need than we.

In the first place we have to make our enterprise attractive to young men in order to secure recruits, and how many mothers are willing to let their sons come to a country when they may be posted 100 miles from medical assistance?

Then we have to consider our wives and families. I consider the present condition in the Annamalais a scandal and matters are not much better in the Wynaad.

And lastly and not least important we have to consider our labour.

The conditions are such that at any moment a planter may be face to face with an epidemic, and apart from his lack of knowledge the conditions under which the coolies live may make that epidemic most virulent.

These conditions can only be improved by an adequate medical and sanitary service.

I would say then that if an Association like the U. P. A. S. I. started a medical service, it might well take its place in the official medical organization of India; it would be helping to fill a national need, for the benefit of future generations as well as this, so the Government should bear a considerable part of the cost and at the same time have a lien on the services of the doctors.

In reply to the questions as to the number of European doctors employed on estates connected with the U. P. A. S. I., and as to whether, if the opportunities for obtaining medical assistance from Indian Medical Service officers were considerably reduced, the number of European doctors employed on such estates would be likely to increase.

As far as I am aware only three districts have European medical officers and in one case the doctor is not resident in the district.

At present the opportunities for obtaining medical assistance from Indian Medical Service officers is so rare that it is inconceivable that they can be reduced, but in any case the number of European doctors employed is likely to increase provided the Government and our community take the right view of the matter.

I would not insist that it is our right to get assistance from the Government, for I believe only officials

are entitled to such, but I feel strongly that anything we can do in this regard can be very little without substantial assistance from the Government.

Can we get the right kind of officers for our work without a guarantee beyond our power to give? And we want the right kind of officer, nothing but the right kind, such as only proper selection and liberal terms can give. The Government assist scientific research, agriculture, education and the like, so surely they will not refuse to assist the bodily health of the people without which the advantages of other assistance are minimized.

Answers to questions for witnesses.

1. I can only answer the first part of this question generally. I know nothing of the Royal Army Medical corps and but little of the Indian Medical Service but it seems to me, since a doctor's profession is the most humane in all the world, that it is the one that should not be subjected to the toils of red tape. As an instance, I was able to procure medicines during the recent influenza outbreak for an unofficial doctor who was going to travel. Having secured them I was asked if the doctor was going out of the district, to which I answered assuredly he was, for coolies are not particular which side of a boundary line they die. Then I was told I could not have the medicines and I had to buy them privately.

I prefer scheme B. I do not like scheme A because of the last paragraph.

I cannot think that a medical service that is not part of the life of a country like India can be any good at all. There may be loss of health from prolonged residence in India, many of us have to face that, but I refuse to believe in the loss of ideals. I think temporary or spasmodic residence in India will not allow ideals to expand. If a man is likely to lose his health, he must be compensated by a liberal salary and a good pension. Less cannot be expected for a technical profession requiring an expensive and continuous education.

I like scheme B because of paragraph 22, but I should like the writer to have included other Europeans in his purview besides those connected with the services.

Special questions.

1. Almost entirely do I think the demands of Europeans for European medical attendance are based on racial predilections and it cannot be otherwise. If Europeans of every sort left India would the practice of European medicine decline? Undoubtedly, and if faith in the doctor is half the art of getting cured, you won't have Europeans going to Indians except in exceptional cases.

2. During the war we have not been able to get satisfactory sub-assistant surgeons in the districts.

Superintendents of estates have relied on themselves and their compounders. In many cases the compounders are not qualified and are therefore liable to big penalties.

3. Without the force of European example the efficiency does deteriorate. Men put in charge of outlying dispensaries or hospitals will wilfully neglect their work, wanting nothing better than to be reported and transferred.

THE HON'BLE SIR F. E. BARBER, called and examined.

(General Giffard.) In the present stage in Southern India the army could not depend to any extent on private practitioners for help in case of an emergency. Such practitioners were mostly elderly persons who had retired from Government service.

Government could encourage the growth of a class of private practitioners, who would form a sort of war reserve and would take the place of military medical officers who might be withdrawn in case of war, by encouraging an association such as the United

13 March 1919.]

The Hon'ble Sir F. E. BARBER.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

Planters' Association of Southern India. Government could help them by the grant of subsidies, and also by grants-in-aid, as the association could not afford itself to start a medical organization. Besides it would not attract the proper class of doctors. A young doctor who stayed in the country for about five or six years and then went away would be useful only temporarily. In order to be really useful he must stay in the country for a pretty long time, and should take part in the life of the country.

He could not speak on behalf of the association, but was of opinion that it would be a good thing to make a money grant to the association to build up a medical service. The association served 14 districts, and it would be quite possible to have a service consisting of 14 or 15 European medical officers with a number of subordinates, provided money were forthcoming. He could not say definitely, but believed that if Government subsidised the association they would be prepared to make up the balance. The medical service at present consisted of only three medical officers in three districts.

(General Hendley.) In one of the districts the nearest medical officer available lived at a distance of 60 or 70 miles. There was work enough for a whole-time Indian Medical Service officer as besides the ordinary hospital work a good deal was required in connection with sanitation.

The state of medical relief and sanitation in the districts could be described as hopeless. It was difficult to get sub-assistant surgeons to come to these districts, and they were anxious to get away, as they were more or less educated persons, and there were no subordinates with whom they could associate.

There was no society for them and no attraction in the life.

In the particular districts of which he was speaking there was one Government dispensary which was very often without a sub-assistant surgeon. This had been built just when the war broke out.

The association would be glad to assist Government in their endeavours to afford medical relief in these tracts, both by their medical officers and their dispensaries. Most of the subordinates were apothecaries or compounders who could not strictly speaking practise under the Medical Practitioners Act. Besides them, the only medical relief available was in the form of drugs kept by the planters themselves for distribution.

(Colonel Shairp.) Three European medical officers were employed by an association subsidiary to the parent association. One of them had been lent by the Travancore State which had a lien on his services, and another was engaged on an agreement for a period of five years.

(General Hehir.) The epidemics that generally spread were cholera and small-pox. In the recent influenza epidemic there was no medical relief available, and nearly 20 per cent. of the people lost their life for want of relief. In the case of an outbreak of cholera there were no means to check it. He had seen patients dying in the verandahs of houses. He had occasionally asked the Surgeon-General to the Government of Madras for help.

He could not speak on behalf of the association but believed that they would be prepared to support a whole-time Indian Medical Service officer if one were lent to them.

17 March 1919.]

Lieutenant-Colonel A. STREET.

*(The schemes and questions referred to by witnesses are contained in Volume III.)***At Bombay, Monday, 17th March 1919.**

PRESENT:

S. R. HIGNELL, Esq., C.I.E., I.C.S. (*Presiding.*)

MAJOR-GENERAL G. CREE, C.B., C.M.G., A.M.S.

MAJOR-GENERAL P. HEHIR, C.B., C.M.G., C.I.E.,
I.M.S.

MAJOR-GENERAL H. HENDLEY, K.H.S., I.M.S.

The HON'BLE MAJOR-GENERAL G. G. GIFFARD,
C.S.I., I.M.S.LIEUTENANT-COLONEL A. SHAIRP, C.M.G., Indian
Army.MAJOR M. T. CRAMER-ROBERTS, D.S.O., Indian
Army.and, as co-opted members SIR T. NARIMAN, Kt., the HON'BLE COLONEL H. E. BANATVALA, C.S.I., I.M.S., and
LIEUTENANT-COLONEL BHOLA NAUTH, C.I.E., I.M.S.MAJOR A. A. MCNEIGHT, I.M.S. (*Secretary.*)LIEUTENANT-COLONEL A. STREET, M.B., F.R.C.S., I.M.S., Senior Medical Officer, Jamsetjee Jejeebhoy Hospital,
Bombay.*Written statement.**Questions for witnesses.*

1. The first defect in organisation is that of having two services in India instead of one. They are, however, both under one head, the Director, Medical Services in India, who frequently knows very little about the most important service. The Indian Medical Service, if enlarged, is fully competent to take over the medical arrangements of a comparatively few more troops. The Indian Army is 224,000. The British is 100,700. The troops will be better looked after by the fact that the Indian Medical Service medical officers are more professionally alive owing to the greater facilities many of them will have had in civil practice; and the natural interest to keep professionally up to date by the hope of the others of getting into civil practice. For this particular reason alone I prefer the broad principle of scheme D, but would alter it in details. These are :—

Paragraph 2.—The name should be the Royal Indian Medical Service. The Indian Medical Service has records and achievements which afford a just pride to its members and make for the *esprit de corps* of the whole force. It is perhaps a question whether Imperial Indian Medical Service would not be better but service is much preferable to Corps as the former includes the civil branch, the latter rather excludes it.

Paragraph 3.—The service should consist only of officers recruited for Indian service, but for the next ten or fifteen years a certain number equal to the pre-war proportion of Royal Army Medical Corps officers may be seconded for duty with this service.

Paragraph 4.—The service shall be under the Government of India partly under military, partly under civil control, but both parts equally available for either duty with the following exceptions, *viz.*, those in civil employ occupying certain posts, such as professorial and specialised professional billets, must be permanently in civil; and those occupying administrative posts such as Assistant Director, Medical Services, permanently in military.

Paragraph 9.—The service shall be officered by its own officers and shall be entered by a competitive examination held both in England and in India, but a certain percentage of marks shall be allotted for having satis-

factorily held hospital appointments and other marks for the advantages gained by having been trained in England.

2. I do not think the approval of the War Office at Home has anything to do with the question of what is best for India. I am sure it will meet the needs of the army in India.

3. Yes. If the service is treated fairly. It is not the scheme which attracts the men but the treatment in service, and I think D scheme is the only one which will meet the demands of professional opinion in England and in India.

4. Proving the absolute necessity of European supervision and throwing on the present staff greatly increased responsibility and extra work.

5. (a) I think so.

(b) No man can be in two places at the same time, so if you withdraw men from civil owing to a war their places must be filled and it is easier to fill these civil billets by temporary men than to put the latter direct into military.

6. It would in an ordinary war.

7. (a) In D scheme, all the junior members would have had some military experience.

(b) Yes, or on leave.

8. Have had no personal experience, but I should say from observation it has proved invaluable.

9. Competitive examinations in which satisfactory hospital experience should count considerably and training in Great Britain should also be recognised as of some educative value. Professional teaching is probably as good in India as in Europe.

10. I would make every officer take one year in six and pay his passage, and I think it certain that most men would voluntarily undertake some study leave as the extra pay is now frequently taken to pay expenses.

11. I do not think research is the work for an ordinary medical service, but if a man in the service desires to take it up, he should be given facilities to do so.

12. (a) In Bombay as far as I can make out about 33 to 50 per cent.

(b) *First.*—The increased number of medical men and the increased professional skill of a fair proportion of them.

Second.—The open antagonism of certain semi-medico-political bodies.

Third.—The derogatory position the Government of India has placed the members of its service in by its rules as regards fees.

17 March 1919.]

Lieutenant-Colonel A. STREET.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

Fourth.—I do not think the treatment the service generally has received during the last 15 or 18 years, has brought out the same class of men as formerly. Many of the prizemen at Netley and the higher positions at the entrance examination now go to the Royal Army Medical Corps, formerly nearly all went to the Indian Medical Service.

Questions to be asked of service officers.

1. I have been 6½ years in military, and 22½ years in civil employment.

2. From the first day of my service up till now Government has done nothing to help me to get as much pay as possible, but puts obstacles in the way.

(a) The fact that pay could be drawn for officiating charge of a regiment before passing the lower standard Hindustani examination was only published in a Government order before I entered the service and the regulations were not corrected, so in my early service I was always attached to a regiment, so that some other officer could draw the officiating pay though I did the work.

(b) During the first plague outbreak I did work under the orders of President, Plague Committee, for several months. Government repudiated his promise to pay on the grounds that I was employed on other work, though for the same plague work that I was doing (inoculation), others got Rs. 200 per mensem.

(c) I enquired from Government if I might be allowed to occupy one of their bungalows and they consented. It was naturally assumed to be on the same condition that other service men had occupied it for the last thirty years. Within a few months of having disposed of my old bungalow Government altered the conditions entirely and turned me out to make room for an ecclesiastical official although on a previous occasion under precisely similar conditions the former ecclesiastic had been refused the privilege of turning out a medical.

(d) The service loses every year a considerable sum of money owing to the interpretation placed on the Royal Warrant about extra pay, but as the Warrant does not say anything about getting the extra pay the Government of India are quite satisfied if a man is selected even though they know he will never draw an extra anna. Surely this is red tape "in excelsis" if not a deliberate attempt to diminish at once His Majesty's favours to the service and its popularity.

(e) Five years ago a Government resolution was passed that the Dean of the Grant Medical College, doing part of the Principal's duties, should draw more than twice the amount the latter does now evidently because the Principal was under paid, and that the Senior Medical Officer at the Jamsetjee Jejeebhoy Hospital should be paid for his work as such. At present his post is completely unpaid. During the war, funds were not available for the extra allowances. Now that they are, Government instead of hastening to pay unremunerated work which they acknowledge deserves pay, absolutely refuse to carry out the scheme regarding the Senior Medical Officer, because a candidate for the other post in a different institution is absent on service. Instead of putting in a man *pro tem.*, they carry on the condemned system indefinitely and save themselves rupees 350 per mensem and of course deprive me (that is deprive the service) of that amount.

(f) When I came out it was on the distinct understanding that private practice was allowed. The restrictions placed on the remuneration

of private practice are the most galling of any, as they not only wound us in our pocket, but in our *amour propre*, in deliberately placing us on a lower level than the Indian (native) practitioner.

(g) The recent orders of Government about giving evidence in judicial cases is not only a blow at the liberty of the subject but another attempt to deprive our service of fees.

Another grievance is that whilst the Indian Civil Service get furlough pay at ½ of their full pay, the Indian Medical Service frequently only get ¼. Our full pay consists of Government pay *plus* private practice, Government by their rules give us half our Government pay on furlough and forbid private practice, so that many Indian Medical Service officers are not in a financial position to take their furlough. This serious restriction was introduced since I entered the service and Government have made no increase for the furlough pay to counterbalance it.

3. I have never met any myself because for the last twenty years have been in civil, but I have heard of cases.

4. One service will abolish all friction.

5. I do not consider that any definite periods should be fixed for transfer from military to civil, or from civil to military employment.

Special questions.

1. This is a question comparatively easily answered in Bombay, because you have here a large number of well educated Indian doctors with degrees as good as any of the English doctors, so the question of education alone may be left out of consideration.

It is almost a nine days' wonder to hear of an Indian doctor attending a European unless financial considerations come into play. An exception to this may be made in case of two specialists.

Besides the racial predilection I think a reason for European shunning the Indian practitioner is their loquacity and also they have not quite the same delicacy in talking about the illness as Europeans.

2. I have had several cases come from the mofussil who have grumbled considerably at their hard luck being left with only Indian assistants and in some cases their grumbling has been justified by faulty diagnosis or treatment.

Questions to be asked of officers regarding assistant surgeons and sub-assistant surgeons.

1. (a) I do not know if there is any. The civil assistant surgeons at this hospital say they have not signed any.

(b) Do not know.

(c) Do not know.

(d) Do not know.

3. Yes, for civil assistant surgeons, but think that promotions to commissioned rank might take place fairly frequently as it is often a question of money only which enables a man to go to England and join the service. Military assistant surgeons should as a class be abolished.

4. (a) Not in a position to say.

(b) Certainly if funds are available.

(c) To all dispensaries and displace the sub-assistant surgeons.

(d) Very considerable extra responsibility and actual work were thrown on the senior officers both as regards professional and clerical work and discipline in the hospital. Men outside the services were engaged to take the place of commissioned officers and many temporary appointments given to newly qualified students.

5. (a) I should make it an absolute essential part of the agreement. No man is fit to be servant of the State unless he is willing to fight for it.

(b) Till useless for military duty.

6. (a) The arrangements for meeting the ordinary medical requirements of the general population in India are probably worse than they were fifty years ago in England.

(b) Control of quackery and increase in the number of medical men.

17 March 1919.]

Lieutenant-Colonel A. STREET.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

(c) Control is necessary for both.

7. (a) I should think he might fill a subordinate place but would prefer an assistant surgeon.

(b) It all depends on what is meant by a resident medical officer, at present he is that officer himself.

8. (a) No.

(b) Such as will fit him for a military duty, such as instruction in drill, regulations and filling up returns.

9. I have no knowledge of his work.

10. Of course they could easily take the place of military assistant surgeons and military sub-assistant surgeons. If the question means could they be employed in addition to the existing staff, I think there would be considerable administrative difficulties in so doing. The reserve will be filled if my suggestions in answer 5 (a) are carried out.

11. None for the sub-assistant surgeon; for the civil assistant surgeon I would allow an entrance to commis-

sioned rank after five years' service on passing a competitive examination.

12. (a) I do not think so if you have some one else to do the work he does. His duties are partly those of a house surgeon, sister, nurse, clerk and steward.

(b) Yes, by employing people specially trained for these posts.

(c) Probably some of the posts could be filled by the Royal Army Medical Corps or Indian Hospital Corps.

(d) Make the junior officers do it as in an English hospital.

13. Have no knowledge of (a), but always thought it was the civil department that relieved the military department.

14. Put him into the civil department if he can pass an examination equal to the others.

15. None in the military assistant surgeon branch.

16. I should try to do without him in that rank.

LIEUTENANT-COLONEL A. STREET, called and examined.

(General Hendley.) He was performing the duties of Principal of the Medical College and Senior Medical Officer of the hospital. Prior to his appointment, these two posts were filled by separate officers.

He agreed with the suggestion to have a senior whole time officer, who would have the rank of colonel, to act as Principal and Superintendent. This officer would hold no professorial appointment and his post in the hospital would be purely administrative.

Bombay had done very well with regard to private medical practitioners volunteering for military duty. The practitioners who volunteered were mostly young graduates without very much experience. Not many of them volunteered for general service, the majority undertaking service in India only. Most of them were employed in war hospitals in Bombay. In the early stages of the war very few volunteered. He did not think that private practitioners of 10 years' standing could be depended on to form a war reserve. They certainly would not go out of the country.

(General Hehir.)—He was not in favour of the conversion of the Indian Medical Service into a corps with military assistant surgeons and sub-assistant surgeons incorporated in it. He thought that the term "Service" was preferable to "Corps" as the former included the civil branch, whereas the latter excluded it.

He was of opinion that the present Indian Medical Service officers were quite able to take over the medical care of British troops in India.

For the efficient working of the service he would allow one European for every four Indians, though personally he would like them to be all Europeans.

All graduates from colleges and universities should be eligible to sit for the competitive examination to be held in India, as a certain number were quite as well educated as those who came out from England. As there would be a considerable number of candidates for the examination he would make a selection, and for this selection he would rely on the Principals of the colleges. He thought it would be a good idea if a few brilliant students who passed the examination were sent to England for further training.

In certain circumstances Indians could carry out the duties of professorial appointments efficiently. They usually lacked ability in maintaining discipline.

He would not make it compulsory for officers of the service to study the vernacular of the district to which they were posted.

With regard to the question of private practice Government had interfered unduly in this matter. He did not think that Government had done right in changing existing rules after an officer had entered the service.

He did not think that the service was as popular in England at the present time as it was some years ago. The Indian Medical Service in India was a very creditable service.

He favoured the abolition of the military assistant surgeon. They were very much lacking in education and they had given him more trouble in college than

all the 800 Indian students put together. He feared that, even if they were given a higher standard of preliminary education and their professional course extended to five years, very few would care to join in a subordinate capacity. The majority of them simply entered the college because they could not obtain anything else to do. He would not go quite so far as to stop recruiting for the military assistant surgeon class. Some one would have to take their places in station hospitals. He thought that some of their duties could be performed by the Royal Army Medical Corps rank and file.

He would militarise all parts of the medical service in India. Every officer who joined the service should undergo a certain amount of military training.

The medical arrangements for India were quite inadequate, having regard to the large population of India. More than half the population of India had only hospital assistants to attend to them.

He did not think that military sub-assistant surgeons received proper military training. In order to fit them for military duty he recommended that they should, while students, receive instruction in drill, regulations and filling up returns.

He was not in favour of promotion examinations from captain to major and major to lieutenant-colonel. He considered this unnecessary.

He was not in a position to say whether a military medical college should be opened in India for the military and professional training of Indian Medical Service officers, as he was unaware of the interests of the military.

He was quite sure that the Indian graduates received a complete medical education in India.

(Sir T. Nariman.) Entrance to the service should be by competitive examination held both in England and in India. The students who had been trained in England should be allotted a certain percentage of marks for having had the advantages of an English training. In his opinion the English trained doctor was better than the Indian trained doctor, and for this reason a certain percentage of marks should be allotted to the former.

The research branch should not be considered a part of the service. He thought that officers who had a special aptitude for such work should be given facilities for carrying out research work.

His experience indicated that very few Europeans liked to be treated by Indian doctors. In Bombay it was a nine days' wonder to hear of an Indian doctor attending a European, unless financial considerations came into play.

He thought that civil assistant surgeons were in some respects quite as good as Indian Medical Service officers. Lack of means very often prevented them from joining the Indian Medical Service. He had some very good students in his college and he was sure that some of them could easily pass the Indian Medical Service examination.

(Colonel Banatvala.) Altogether there were about 700 private practitioners in Bombay. He was not able to

17 March 1919.]

Lieutenant-Colonel A. STREET.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

say how many of these had volunteered for military duty during the late war. From his college 70 out of 120 applied to go on military duty.

A student, before he went up for his examination, had to conduct six midwifery cases personally. Besides the six cases conducted personally, he also saw other cases that were being conducted by others. The students in his college had every opportunity for studying gynaecology and diseases of children. In his hospital there was a special ward for children, to which students were admitted for the purpose of attending cases. He did not think it was necessary for an intending candidate for the Indian Medical Service to proceed to England to take special courses in gynaecology and diseases of children. An officer on the staff of a London hospital had told him that there were more opportunities here than in England.

The small dispensaries which had been established in India were very useful in preventing disease. During

the recent influenza epidemic these dispensaries had done a lot of good work. India required a great many more doctors for its civil needs and these should be better trained men.

(Lieutenant-Colonel Bhola Nauth.) He would not place any limit to the number of Indians entering the service. He knew of no method by which to prevent Indians of low caste entering the service. By low caste he meant Indians with little or no social standing.

He did not think the service was obtaining a good class of men at the present time. He put this down to the treatment of the service.

(General Giffard.) The witness had been under the impression that scheme D aimed at having one service only. When it was pointed out that scheme D meant a separation of the civil and military services he said that he had not read the scheme properly, and in the circumstances he could not agree with it.

COLONEL F. A. F. BARNARDO, C.I.E., I.M.S., A.D.M.S., Embarkation Staff, Bombay.

Written statement.

General considerations.

In any approved scheme for the reorganisation of the medical services in India, certain fundamental principles appear to be essential. These are:—

1. The adequate medical needs for the army in India in peace.

The two present military medical services in India provide inadequately and unevenly for the medical needs of the army in peace time.

A single military medical service would undoubtedly be of considerable advantage in smoothness of working and advantage to all concerned and the introduction of the station hospital system into the Indian army administration has undoubtedly, though it has many disadvantages, rendered any amalgamation of the two services a considerably easier problem than would otherwise have been the case under the regimental system.

The anomaly of having two military medical services in India would with advantage be rectified and the proposed amalgamation of the two services appears to present no difficulty whatever provided the civil side of the Indian Medical Service is cut adrift from the military side. This amalgamation has practically been already in practice through India for the few years of war as in many cases temporary Royal Army Medical Corps officers have been at work in Indian troops' hospitals, and the result has been complete smoothness and efficiency.

As the organisation and administration of the future single army medical service in India would undoubtedly depend on the nature of the future Indian Army and little remains here to be said until the War Office have decided whether they or the Government of India are to have the control of the British garrison in India.

2. The adequate medical needs of the army in India in war including the question of an adequate war reserve.

The present military medical service in India does not provide for the needs of the army during war, as its war reserve was not sufficiently large, judging from the fact that over 800 temporary Indian medical practitioners had to be engaged and given temporary commissions in the Indian Medical Service in addition to the hundreds of temporary Royal Army Medical Corps officers from the United Kingdom attached to the army in India.

The conditions of service whereby the officers of the Indian Medical Service have in times past been granted military rank and must have completed a minimum of two years' military employ before transfer to the civil branch, are apparently based on the importance of

maintaining a war reserve in case of national emergency.

The success which attended the measure whereby the 800 Indian practitioners referred were enrolled and granted temporary commissions in the Indian Medical Service to make up the deficit in the war reserve is worthy of consideration and it appears that in future a war reserve could be built up in India by establishing for Indian medical practitioners, a scheme whereby they would by the grant of rank and pay be induced to undergo a few months (annually or bi-annually) of military medical training with the local Indian Defence Force. This would soon ensure a maintenance of efficiency in field medical training and in military medical matters generally and thus abolish the necessity of calling out on the occasion of a war of any magnitude greater than a small frontier show, the solitary representative of European medicine in each district—the civil surgeon.

In addition the success of the scheme whereby large numbers of Royal Army Medical Corps officers have been drafted to India for duty in India cannot fail to suggest that a similar portion of the future war reserve arranged for might easily be maintained in England itself.

The necessity of holding the civil branch of the Indian Medical Service as a war reserve in case of emergency would appear to be entirely unnecessary. During the present emergency these 800 temporary Indian medical practitioners have been recruited and granted temporary commissions, and the numbers could be indefinitely increased. Many of these have performed the most excellent work. No doubt there have been many disabilities on account of their want of previous military training, but this could all be rectified by the establishment of a special reserve of medical officers such as at Home whereby for a period of military training and the grant of a honorary rank, a large number of the Indian medical practitioners could be registered and be available for duty with the army in time of war.

It would also be necessary to have specialists and consultants for the army in times of war such as is not necessary in times of peace. For this purpose any officers in civil employ who are specialists could be called out for duty in their own special branch, but under no circumstance ought it to be possible for a skilled medical man at the age of 40—50, who has devoted his whole life to the education of his eyes, ears and his fingers to the practice of his profession, to be recalled for military duty in a war emergency, to occupy the post of officer commanding, station hospital, or officer commanding field ambulance, or Assistant Director of Medical Services. This practice though reprehensible enough in war is still more so in peace time and it is impossible to conceive a greater example of inconsistency or waste of skilled material than the present system whereby a senior officer of the Indian Medical Service—

17 March 1919.]

Colonel F. A. F. BARNARDO.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

a specialist, say, in midwifery and the diseases of women—who has devoted his whole life to train himself and become perfect in this one special branch, is taken away at the age of 47 or 48 when he is really in the prime of his life and of the greatest avail as a healer of disease and as a teacher of the young Indian student—to become an administrative officer and be appointed Assistant Director, Medical Services of a Brigade; and one can only say that if such a professional man is able to perform the duties of an Assistant Director, Medical Services, Brigade, satisfactorily, then there can be nothing whatever in a military medical training and no advantage in any medical officer attempting to train himself into the needs of the army in war or in peace.

The recall, therefore, of senior officers in civil employ into military employ for administrative purposes does not appear to be a measure calculated to promote efficiency and officers permanently in civil would be better employed as professional men and not as administrators.

3. *The adequate medical needs of the civil population of India (European and Indian) in peace and in war.*

The present Indian Medical Service does not provide for the full medical needs of the civil population in peace as only one civil surgeon is settled in each collectorate.

In some cases this collectorate, in which he is the only medical officer, consists of two million inhabitants. It may be two hundred or three hundred miles in length with some forty outlying dispensaries and a large central civil hospital, jail, large police training school, etc. The vital statistics alone occupy or should occupy a very large amount of his time. The whole questions of sanitation—malarial prevention—the outbreaks of disease in epidemic form, especially where plague and cholera are concerned—or small-pox—are of the greatest importance to the future of the country and it is perfectly obvious then that with this very large sphere of work a single European medical officer is entirely inadequate for the provision of the medical needs of the civil population and yet in order to provide a war reserve this is the officer who is considered as available to be immediately withdrawn for active service.

The present conditions under which this solitary European civil surgeon of such a district can be recalled to military duty on any emergency—to leave the medical and sanitary charge of his district to its own devices for a period of years while war lasts—are surely archaic in conception and unworthy of the trust that the British Government has taken on its shoulders, i.e., to bring western medicine within the reach of all in India whether rich or poor.

The civil cadre of the Indian Medical Service is never sufficiently large enough to enable the civil surgeon to be relieved at intervals and avail himself of his leave until he has become stale and his energies have become sapped.

Any new scheme would advisably increase the cadre of the civil medical service so as to provide for at least two medical officers in each district—one as civil surgeon and the second to act as his assistant. It is further very advisable that in each station a certain number of Indian practitioners should be encouraged to undergo special courses of training whereby they may be appointed Government specialists so that the civil surgeon may have at his disposal for the benefit of the civil population at large, the services of an X-Ray specialist, a bacteriologist, etc., in each district.

The above, of course, refers to the Indian population, and what can be considered of the Indian population, can be said ten times more with regard to the European population. It is more than desirable for many reasons, that all the European officials and the European population in each district should have the benefit of one of their own countrymen to attend them if they so desire, and under these conditions it seems certain that the whole of the present cadre of the European officers of the Indian Medical Service in civil employ should be considered as the residuum of officers indispensable to carry on the ordinary machinery of the country and these should not be available to act as a war reserve which can

easily be filled up by Indian medical practitioners with a certain amount of military medical training, except in cases where the civil surgeon's services may be required as a specialist or a consultant to the military forces in times of war—leaving his young assistant, if competent, to act for him in his district until the emergency is over.

4. *Organised research work.*

The present military medical services do provide, as far as financial considerations render it possible, for a limited amount of research work, but in a manner quite unworthy of the richness of the material at hand and the prospects of ultimate benefit to the scientific world at large and the population of India in particular.

So far the brilliant results of research work in India have been effected mainly by the individual efforts of the Indian Medical Service men, who, despite frequent moves, despite financial difficulties, have persevered in the interests of the work at heart.

The research work of the future Indian Medical Service may very well be regarded as a "reserved subject" of the Montagu-Chelmsford scheme and dealt with by the Government of India itself as a great trust of the service from the civilised world at large in addition to any local organisation by the medical departments of the provincial governments.

There is probably no country wherein diseases of every kind are so widespread as in India, and, therefore, the whole question of research work is a national one and it should not be hindered by service conditions in war or in peace, but should be directly under the Government of India under the immediate administration and encouragement of the Director General, Indian Medical Service, who would then direct and organise research work in such directions as he considered of premier urgency.

5. *The provision of such conditions of service for the future which will be alluring enough to attract the best medical graduates (both Indian and European) of the highest mental calibre in each year.*

In this connection it is very important to remember that it is the best European brains and the best Indian brains we wish to attract. The best Indian brains would be a permanent asset to the country while it is only the best European brains that could be educative and serve as the connective link between the vast field of clinical material in India and the latest development of scientific thought in western schools.

Assuming that any reorganisation of the existing medical services must comprise a military branch and a civil branch, let us first consider attractions in each branch for:—

I. INDIAN GRADUATES.

(a) *Military branch.*

There is the keenest competition among the youth of India to have an official position. The official position is more easily obtained by the possession of army rank than by any other appointment in Government service and it would appear that there would be no difficulty whatever in obtaining good Indian competitors for the military medical side of the Indian Medical Service under any conditions of service whatever.

For the recruitment of these graduates, it would be necessary in order to ensure their adequate comparative social position to have the selection of these by competitive examination at Home.

(b) *Civil branch.*

With regard to the Indian practitioner, it appears that there will be no difficulty in obtaining the best recruits for any Government civil medical service seeing that the living rate of pay and pensions for Indians, etc., are all provided by conditions under any new scheme and we can safely say that the standard of the future Indian recruit to any new service in its

17 March 1919.]

Colonel F. A. F. BARNARDO.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

civil branch will depend entirely upon the standard and the ideals of western medicine with which he has been instructed in the past few years of his medical training in the medical schools in India.

I would lay the greatest stress upon the medical education which the Indian student receives in all the medical schools and colleges of India as I am convinced that on it entirely depends the success of any scheme which includes the admission of Indians within the ranks of the service it proposes to organise.

The selection of the teaching staff in any of our large medical schools in India has hitherto practically entirely been made by seniority. The result is that though a senior officer may be a very good clinician or a good surgeon, he may be quite unable to teach or in the least way impart the ideals of western medicine or instil that "character" on its young student which is so conspicuous in western schools whereby the young graduate of a western school is told what "not to do," "what not to say" and "what not to think"—in striking contradistinction to the method which from personal experience I have witnessed in more than one medical school in India by which the young graduate is taught "what to do," "what to say" and "what to think."

If then the teaching staff be selected for character, personality and teaching ability it need have no fear that the best Indian brain will not very quickly absorb the ideals of western medicine and that under the improved conditions of any new service, the very best of these graduates of each year will enter the service, the members of which acted as their preceptors or teachers.

At present almost without exception, officers of the Indian Medical Service—surgeons in civil employ—are regarded with coldness and indifference by all the Indian civil medical practitioners in his district. An exception may be made in the case of some of the older Indian practitioners. The reason is not far to look for.

The teachers in the medical schools of old were men of character such as Cheevers, Childe, etc., who imprinted their personality on their students with the result that their precepts were never forgotten and their successors are venerated with the veneration of the student for his teacher. Of latter years the modern student has no such teacher to look up to and owing to the mediocrity of the teachers in the medical schools of to-day the service generally suffers from the inference that if the professorial staff of the medical college being picked men are mediocre, then the remainder of the civil surgeons of that province are more indifferent still.

It is to this attitude of the indigenous medical practitioner more than any other the gradual loss of private practice which is experienced by all civil surgeons is due and any new scheme for the restoration of favourable conditions for the civil branch would with advisability pay considerable attention to the selection of the professional talent in all the medical schools and colleges throughout India.

The selection for professional appointments should be made by the Director-General, Indian Medical Service, from the whole of the cadre of the service and not by the provincial government of the province in which the medical school happens to be situated.

II. European graduates.

(a) Military branch.

It would seem justifiable to assert that no matter how attractive conditions were made in any new military medical service, they would never attract a single graduate of the mental and scientific standard of those who up to now have been among the competitors for the Indian Medical Service.

If any medical graduate desires a military life, he can get all he wants in the Royal Army Medical Corps, and if ever there was any attraction in the old regimental system of the Indian Medical Service, this has been absolutely wiped out by the introduction of the station hospital system.

(b) Civil branch.

Practically the whole of the Indian Medical Service recruits enter the service from a keen sense of professional interest and desire to avail themselves of the very large clinical fields which present themselves in India and unless there is some certainty of realisation of their professional work, the best European graduate will prefer to remain at Home where he can take up any branch of science as may present itself.

A very important point in the attractive conditions of any civil branch is the non-interference with private practice, the recent rules regarding which have had more to do than anything with the prevention of graduate competitors from appearing for the recent service examinations.

In order to ensure that an officer can avail himself of this professional work that India can provide for him, each officer in civil employment must be allowed to remain for a considerable period in one place and not to be subject to frequent transfers whereby all his experience in certain climatic conditions is lost entirely. Further he must be allowed to keep himself up-to-date with the most advanced science at Home by regular periods of leave. This will involve then a very much larger cadre in the civil branch than has heretofore been conceived of and any new scheme which will attract the best form of European graduates must provide for the cadre being sufficiently large enough, whether European or Indian, to enable these two latter points to be taken advantage of.

It must be clearly borne in mind that the market value of a medical man at Home stands now at £1,000 a year and under these conditions unless a man is exceptionally keen on his professional work, other attractions in the conditions of any Indian Medical Service may not tolerate any reduction in this scale of pay.

The market value of a railway, or of a tea planter's doctor in India, is also about Rs. 1,000 per mensem and, therefore, the scale of pay of any new scheme must be one which will compete favourably with this—of course making the necessary reductions for pensions, etc., in the usual way, otherwise the best graduates of each year will not dream of entering any service in a country like India which is bristling with disabilities of every kind.

6. Any new scheme must provide for the rectification of present disabilities under which the present officers of the Indian Medical Service are laboring.

No officer of the present Indian Medical Service would ever put his son into the Indian Medical Service. He would shudder at the thought that after providing for a public school and a Varsity education, his son would spend years of the most gruelling study to enter a career in a service whose members are thoroughly discontented and dissatisfied.

It is perfectly clear that the greatest dissatisfaction and discontent does exist amongst the present members of the Indian Medical Service. We may ask why? We may ask where have the conditions experienced in India fallen short of—or falsified the expectation and realisations of the medical graduate, who was induced by the Secretary of State's circular regarding the Indian Medical Service to appear for the competitive examination.

The causes of this discontent have been much discussed recently by the members of the service generally and their case is stated fairly accurately in the recent memorandum to the Secretary of State by the British Medical Association. Inadequate pay with increasing cost of living in both branches—civil and military—with difficulties of leave, inequalities of promotion as compared with the Royal Army Medical Corps in the military branch, interference with and a decreasing private practice, in the civil branch, etc., have so far occupied the foremost place as the specific points of dissatisfaction amongst the members of the service. In other words the attractions held out on an officer's first commission are found now to be not realisable under existing official and economic conditions at present prevailing in India.

17 March 1919.]

Colonel F. A. F. BARNARDO.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

The causes of discontent mentioned above which are mainly financial, are very definite and real; still they are not unsurmountable and the members serving in each province, place their own weight on one or other of the points mentioned.

It is, however, clear that the discontent and dissatisfaction which is widespread amongst the members in civil employ in every province and in military employ cannot be due to money and money alone. This would never have produced a practical boycott on the service from the recruiting point of view in all the large medical schools in the United Kingdom.

Had the disabilities of the service been only financial there would certainly have been some "solitary" scientist who would have given himself to research work or purely professional work and like "Galileo" of old—"care for none of these things." But we look in vain for such a contented one throughout the service. The underlying thought of every officer of the service is that he is made to feel, whether he is in military or civil employ, that he is a member of a subordinate service.

On the military side the medical branch is relegated to a purely subordinate position, *viz.*, a non-combatant one, and this classification has resulted in a tremendous loss of prestige and position, which is bound to reflect on the efficiency of any military medical service and of the support which it can render in times of emergency.

Almost more so in the civil branch. The Inspector-General of Civil Hospitals of a province has little or nothing to do with the administration of his men. Appointments are made and leave is granted by that member of the provincial government who includes the medical and sanitary service among the "etcetra" of his portfolio. Every officer in civil employ feels that the lot of a member of the Police or Public Works Department is infinitely preferable in that the former has a member of the Civil Service as his chief whose recommendations are listened to, while the latter has a Secretary to Government with two Under Secretaries all of his own service and any recommendation disciplinary or otherwise, are represented to Government directly by his own representatives.

It is this subordination in official prestige and position that is really at the bottom of the discontent of the Indian Medical Service members. They express it saying that they cannot get leave—they cannot get enough pay, enough professional practice, etc., but what is really felt but unexpressed, is, that the position of every service member, whether junior or senior, is merely a subordinate one. This renders the conditions of present service more than difficult.

Thus you have in India the most highly trained, highly educated and the most highly scientific service, subordinate entirely to the combatant branch of the army while in military employ and to the civil service while in civil employ. The mere subordination of the individuals of the service itself would be nothing at all if the heads of the medical service in each province were free to administer their own service—but such is not the case. In the military side, with the exception of a few administrative moves, the recommendations for promotion, the recommendations for senior official appointments, the smallest financial powers, etc., and everything of this nature are entirely withdrawn from the medical administrators.

In civil employ as stated above the members of the service are transferred and appointments are made by the Secretaries in the Department of Government which administers medical and sanitary matters.

The result of this is that every member of the service feels himself an absolute "lone bird" with no real head to advise him or to whom he can appeal with any chance of success. He is left entirely to his own resources. He feels that he has no real head to fight for him and after a few years of service in a country where two ends can hardly be met, he becomes tired and discontented with the result that his efficiency is impaired.

Any scheme then for re-establishing popularity of the service must, in my opinion, take this fundamental

cause into consideration. The prestige of the service, etc., can only be restored by improving the position of the administrative heads of the service. On the military side the Director, Medical Services or the Assistant Director, Medical Services, should then, with advisability, be on the Staff of the General to which they are attached, with powers of direct approach to him and on the civil side by the Director-General, Indian Medical Service, being the Secretary to Government in the Medical and Sanitary Departments, while the Surgeons-General would be Secretaries to their Governments in their own Departments while the Personal Assistant should be Under Secretaries.

It is interesting to trace in a little detail the career of any present officer of the military side of the Indian Medical Service from the date of his appearing for the Indian Medical Service examination and his difficulties will be readily seen.

The officer will have joined the Indian Medical Service in preference to the Royal Army Medical Corps as stated above on account of (1) the attractions of clinical material in India, and (2) merely secondarily the advantages in pay and the possibilities of a private practice enabling him to retire at the end of his service with something more than the small pension such as is obtained in the Royal Army Medical Corps.

He entered the service with scientific and professional keenness and anticipated that after two years of military employ he would be transferred to the civil branch. He finds that after two or three years of frequent changes in military employ there is little or no chance of being transferred to the civil branch; and year by year as their transfer is delayed they all become disheartened.

He may, in his dissatisfaction with the narrowness of military life and the small demands made on his skill and intelligence, seek to leave it by going into political employ, jails, chemical examiners department, etc., and in fact anything to escape from the life of idleness, and for the moment the novelty of the new field is attractive.

It is perfectly true that any young unmarried officer who is a keen polo-player or a keen shikari, does find a temporary attraction in military life with sufficient pay as a bachelor to live on with all the benefits of regimental life and no responsibilities and he is reduced from his original scientific ambitions and he consents to remain on the military side by being attached to some regiment. As long as he remains single with his regiment, all goes well, until such time as he gets married—now say with about 10 to 12 years' service. Then he finds his pay is insufficient to send his wife to the hills every year: when children arrive, under the increased expenses he does not know how to make ends meet. His wife has to go Home frequently and he is constantly in debt. He has no opportunity of private practice and a very uncomfortable position is his lot. He may go on service with a field medical unit and return to his regiment to find a new set of officers who "know him not." All his companions who were in the regiment when he joined it have disappeared on staff or departmental billets and all the attractions of the comradeship of regimental life has thus disappeared and he now finds he is merely the "M. O." and not one of the regiment.

During the whole of his military service all the disabilities referred to above in the absence of any administrative head with any real administrative powers have been experienced by him; any question of staff appointment, specialist appointments, promotion, transfers, will have to be dealt with in a manner which he considers wrongly or rightly without consideration or sympathy and he is made to feel throughout the whole of his military medical career that if he has a good time at all, it is only because that he himself is a good fellow, and not because he is an officer in a good service. In other words, he is in the army but not of it.

In times past the Director-General, Indian Medical Service, has regarded those members of his service who have elected to remain in military as "black sheep" and as only having wasted their time for the years they have spent in military employ. In attempting to make the military side popular with the Indian Medical

17 March 1919.]

Colonel F. A. F. BARNARDO.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

Service officer there seems very little chance. Recruits out for a military life or a military career can get all they want in the Royal Army Medical Corps and any new scheme for a unified military medical service for India thus can only succeed by introducing such conditions as will entice Royal Army Medical Corps officers to be attached to or permanently transferred to it.

Under the station hospital system all the attractions of the regimental system have disappeared and the last remaining inducement for an Indian Medical Service officer to remain on the military side has vanished.

Conclusions.

The following conclusions then appear to have resulted from the above general considerations and it would be advisable to so construct any new approved scheme by including these as fundamental axioms.

Constitution of the new medical service.

1. (a) With regard to the military branch it is immaterial whether a reconstituted Indian Medical Service absorb the Royal Army Medical Corps or *vice versa*; neither service from a military medical point of view will attract the Europeans who in times past have filled the cadre of the Indian Medical Service while the aspirations of the Indian for a military medical career must be satisfied and either the conditions of the Royal Army Medical Corps must be changed in order to accept Indians within its ranks or else the new Corps must be an Indian Medical Corps with seconded Royal Army Medical Corps officers retained.

It seems perfectly clear that the military side of any medical service for India must be entirely divorced from the civil side as recommended by the Royal Commission. If this is done, there is no difficulty with regard to the organisation of the reserves with one military medical service which will admit Indians into its ranks, with Royal Army Medical Corps officers, temporarily (five years) or more or less permanently attached to it.

There would thus be two services—one a military medical service to include Indians—to be called "Corps," "Service," "Indian" or "Royal Indian" and on the other side—a civil medical service.

As an attraction to secure the services of the best Royal Army Medical Corps officers to the military service, it might be possible to suggest that say 5 per cent. of all appointments to the civil service be offered to these officers each year who have elected to be seconded permanently for duty in India.

The recruitment for both the military medical corps or service and the civil medical service to be by examination at Home to ensure the necessary standards in social position and medical training being maintained.

At any future date if the standard of teaching, etc., in the medical schools of India is organised to render the possibility of this examination possible, such a change can be readily introduced.

2. The appointment of the Director-General, Indian Medical Service, as a Secretary to Government and the Surgeons-General in each provincial government as Secretaries in the Departments of Medicine and Sanitation with the Personal Assistants as Under Secretaries.

3. The enlargement of the cadre of the civil branch of the service, however, constituted in order to obviate frequent transfers and to enable sufficient leave to be taken whereby the man may keep himself up-to-date.

4. The selection of the teaching staff of the medical schools throughout India to be exercised with the greatest care and selection without regard to province or seniority.

5. The provision of a war reserve from the Indian medical practitioners of India.

All European officers who are in civil employ to be regarded as the "residuum" of officers necessary for the needs of the civil population: these should only return to military duty in war time—not as administrators, but as professional men, specialists or consultants.

With these points in view the consideration of the details of any special schemes as A, B, C or D, sub-

mitted, is very largely superfluous. All contain one or other of the essential principles and only a definite knowledge of the future, especially of the Indian army with its proportion of British troops would enable a definite conception of a final approved scheme to be clearly made.

The very important questions of the future of Indian Medical Department with its assistant surgeons and sub-assistant surgeons and the employment of Royal Army Medical Corps ranks and the organisation of an efficient Army Hospital Corps have not been touched on as involving a question of detail rather than of principle, once a single medical corps for the army in India has been arranged for with its separate civil medical service.

Appendix I lays down a short sketch of a scheme for a Cadet College for the future new Indian Military Medical Corps and it seems reasonable to suppose that practically all the disabilities under which European officers of the service find themselves in the army and many of those which Indian officers of the service would experience, are removed by the establishment of such a college.

APPENDIX I.

ESTABLISHMENT OF A MILITARY MEDICAL CADET COLLEGE FOR A NEW INDIAN MEDICAL CORPS.

1. The difficulties of attracting really good young medical officers to consent to choose a career permanently in India must be faced. The Royal Army Medical Corps will have no such difficulty as their service is primarily at Home with only intervals of foreign tours which are full of interest.

Further, as the new service is to be a military medical corps it must be military in its outlook and enjoy a standing and prestige common to all the branches of the army, with whom it is in daily contact.

It cannot be denied that at present this is where our present Indian Medical Service fails. The election of the Indian Medical Service as a career was not influenced by the glamour of the army with its prestige and position. Some who ultimately enter the service have tried private practice at Home and have realised its drudgeries and its difficulties. Others who may be aspirants to consultant fame have been unwilling to undergo the long weary waiting that consultant practice demands; and practically all members of the service were attracted by the certainty of (1) a definite assured income and pension and (2) opportunities for professional work in addition the promise of a reasonable remuneration. In other words in the past the selection of the Indian Medical Service as a career has been due to influences which have been felt subsequent to obtaining the Medical Diploma, *i.e.*, after five years of the most exacting course of study, when a young medical man is not able to incorporate himself with the ideals of military life or to deal with the problems of the army which will confront him from either within or without, from the military standpoint.

But we all feel that though now we are officers in the army, we have not that prestige and position among combatant officers of the other Army Departments which officers of any branch or department are entitled to expect. This is mainly due, apart from a few instances of lack of military bearing and ignorance of military customs and usages to the inability on the part of medical officers without an efficient military training to enter into the atmosphere of military life with a military outlook and from a military standpoint. The provision of an efficient military training at the outset is then to be provided for.

It is this inaptitude then to associate himself with military ideals that has proved to be a stumbling block to the admission of the medical officer of the army in the past from being accepted on the same terms as the officers in the combatant branches of the army generally.

The recruitment for all other branches of the army is not left to chances. The young man of 18 is taken after competitive examination and admitted to Sand-

17 March 1919.]

Colonel F. A. F. BARNARDO.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

hurst and given his insight into life from the military aspect with military ideals under supervision. There is not any definite reason why a different course should be pursued in the case of the medical officers of the army and it seems essential that if the disabilities of the military medical officers are to be removed, he must too be taken at the impressionable age say of 18 and introduced into military life with like military ideals in a military medical cadet college where his surroundings and atmosphere are military and not civil.

2. The new corps could be recruited by competitive post graduate examination as at present, but this plan has little to recommend it. It seems more suitable that the selection of the future officers of the corps at the outset of their medical curriculum, by the establishment of a military medical cadet college. This principle is adopted in the French Home Army by the establishment of its Medical Cadet College at Lyons, and its college at Bordeaux for the Colonial Army.

The advantages to be obtained by the establishment of such a college are many:—

1. The ideas of the young cadets can be moulded according to military ideals, which are so necessary in their army life.
2. The cadets, as medical students, can be guided and supervised during the trying ordeal of five years of studentship.
3. Any racial prejudices which unfortunately may ever have existed in the past between European and Indian officers will be quickly overcome in thus bringing them into daily contact at an early age.
4. These prejudices, if allowed to continue, will hinder, apart from all other considerations, the progress of scientific effort and of science in all its branches, during the forthcoming struggle in India of hygiene and sanitation on one hand and lack of education among the masses in this country on the other.

The close association of young Indians and young Europeans in their sports and in their studies, consequent on residence under the same roof and under the same conditions of discipline, will lead to the establishment of a high *esprit de corps* in the service of which they are ultimately destined to become officers. The outlines of such a cadet college are as under:—

3. Such a military medical cadet college could be established in London much on the same lines as Sandhurst or Woolwich.

The advisability has been considered of establishing other colleges in Edinburgh, Dublin, etc., but the benefits to be obtained by the residence in a single college of all future officers of the corps outweighs other considerations.

Entrance to the cadet college would be by examination in Arts subjects, up to the standard of the London Matriculation Examination to be held in Calcutta and in London. The age of candidates should be 17 to 19 years. The number of candidships would depend on the number of commissions to be offered year by year. The proportion of Indian cadets to European cadets should be fixed at 50 per cent. and in order to ensure that the suitable class of candidate presented himself for the examination all desirous of entering the new cadet college should before this examination present himself before a board to be passed physically and socially fit to hold the King's commission.

This in India should include Indian gentlemen of high standing.

NOTE.—The possibility of obtaining cadets has been considered at, say, the expiry of their 3rd year in the medical curriculum in any school whether in the provinces or in India but the advantages are slight and disadvantages are many.

4. The successful candidates from India or England would then be required to enter into a bond or agreement with Government as to his future career.

The sum, say, of £100 annually would be payable by the cadets' parents or guardians to Government,

who would be responsible for the payment of all fees for his medical curriculum.

As the cost of such a curriculum at any of the London hospitals averages about £44 a year, a balance of £56 would be in hand for the expense of this college. With say 50 new cadets arriving each year the total number in residence would be 250 which would provide a sum of about £14,000 annually. Free scholarships for Kings' cadets or others who might prove themselves worthy could also be provided out of the sum.

5. The staff of the college in outline would be:—

- | | |
|--|-----------------------|
| (1) 1 Commandant—preferably a member of the Board at the India Office. | } for infantry drill. |
| (2) 1 Adjutant | |
| (3) 1 Quartermaster | |
| (4) About 50 orderlies | |
| (5) A Sergeant-major | |
| (6) A Sergeant-major for riding school, etc. | |

6. Each cadet should be allowed to select his own medical school (Barts, Guys, etc.). On successfully completing his medical curriculum by obtaining his medical diploma (which should be left to the choice of the cadet himself), he should remain at the college for a course of 3 months' instruction in military medical subjects at the expiry of which period he should undergo an examination in those subjects taught at the college.

- | | |
|------------------------------|--|
| Military training. | } All subjects as at present sent taught at Aldershot. |
| Infantry drill and training. | |
| Riding school tests, etc. | |
| Hospital administration. | |
| Medicine and surgery. | |

On the place obtained at the first competitive examination the seniority for the time being of each cadet shall be decided and he should then obtain the rank of lieutenant.

7. In the event of any cadets being unsuccessful in obtaining his medical diploma in 6 years he should be considered to have forfeited the articles of his bond and should not be eligible to enter for the first competitive examination for commission (except under such special circumstances as illness, etc.).

In the event of any cadet being unable to complete his 5 years at the college (say due to death of father or guardian) such case shall be specially referred to the India Office for decision.

The three months' summer vacation of the medical schools shall be spent—

- One month on leave.
- Two months in military training with some medical territorial unit or army unit.

8. On successfully obtaining his commission the pay of lieutenant should be at the rate of £250 per annum until the date of his landing in India when his pay should be allowed at the rate laid down under the heading "Pay" and his years of full pay service in India will count from that date.

9. On arrival in India lieutenants should be posted to a school of tropical medicine in India where they should undergo instruction in tropical medicine, tropical hygiene, bacteriology, etc., and in military surgery. This course should be for six months, at the expiry of which time a second examination should be held in the subjects taught at the tropical schools. On the aggregate of marks obtained at the first and second examinations the final position of each lieutenant on the gradation list will depend.

10. Officers then will be handed over to the Director-General of the new corps and detailed for duty in any military station.

NOTE.—The advisability of establishing another college in India (say Calcutta) which, though it possesses many apparent advantages to the Indian cadets, will not, we believe, be so acceptable as a single college in London, for the following reasons:—

1. The opportunity of obtaining a medical education at western medical schools at a comparatively low cost.

17 March 1919.]

Colonel F. A. F. BARNARDO.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

2. The European officers of the service would have no advantages of a training in western schools over the Indian officers who might only be educated in Indian schools; for, however, excellent this education could be made still men trained in western schools which lead the way in modern western medical science will always have superior qualifications.

3. All Indian permanent officers of the service, who have been consulted are in hearty approval of the single college in London as opposed to two, one in London and one in Calcutta and it is justifiable to assume that though many at first will look with disapproval on this idea, still the advantages of a complete medical training in London are so obvious that in a very few years, all Indian candidates will prefer to go to a London College rather than one in Calcutta.

COLONEL BARNARDO, called and examined.

(Mr. Hignell.) The districts in Bengal were of a very large size, and it was impossible for one civil surgeon to cope with the medical requirements of a district, and to run the district really satisfactorily. Besides the question of the large number of the civil population, the more important thing was that the districts in Bengal were so full of disease such as malaria, cholera, etc., that there was no clinical material like that in the whole world. Every conceivable disease was prevalent there with the result that the field for work was enormous. Apart from this and ordinary official duties the work in connection with the preparation of vital statistics alone occupied a considerable portion of his time. Besides this he had to look after 30 to 40 outlying dispensaries, and attend to jail work, etc. Thus the work devolving upon a civil surgeon was very great indeed for one officer, and yet the civil surgeon was part of the war reserve and could be withdrawn in time of war. It was absolutely necessary that the appointment of civil surgeon should be treated as a residuary appointment.

The aim and object of Government was to bring the western system of medicine within the easy reach of the population, whether rich or poor, and in order to attain this object every civil surgeon must be left sufficiently long enough in a station to become trusted by the people. In addition it would be well if he had a staff of local Indian practitioners, to help him, who were trained as specialists in subjects such as X-ray, bacteriology, etc.

By saying "The research work of the future Indian Medical Service may very well be regarded as a 'reserved subject' of the Montagu-Chelmsford Scheme" in his written statement, he intended to convey that research work in any scheme for re-organisation of the medical services might be compared to a "reserved" subject of that scheme.

With reference to the remark in his written statement to the effect that officers of the Indian Medical Service—civil surgeons—were regarded with coldness and indifference by all the Indian civil medical practitioners in the district, he explained that this was brought about by the mediocre abilities of the professors of the medical colleges. They were teachers of mediocre qualifications and inspired very little respect among their students. The assistant surgeons turned out from the colleges who established practices in the district had thus no veneration for their professors, and, if they had no real veneration for their teachers, they would be led to the conclusion that, if the professors, who were supposed to be picked men, were of the mediocre mentality they found them to be, the civil surgeon must be a more inferior man and not worthy to call in for consultation. They thus lost all the respect for the civil surgeon, and thus the popularity and prestige of medical officers in the services in the mofussil generally suffered on account of the want of special teaching qualifications of the professorial staffs. In making these remarks he wished to point out and lay the greatest stress on the extreme importance of making a careful selection for the professorial staffs. They should not be selected merely on account of the length of their service, but on account of their intrinsic personality and their capability and aptitude to teach students. The best men available should be selected to fill these posts, and if a really good officer was not available in one province, selection should be made from the other provinces.

He was opposed to frequent transfers of civil surgeons from districts and recommended that medical officers should be allowed to remain in one district for a fairly long time. For instance, if in a malarious district a civil surgeon had acquired a fairly good experience, and had studied the problem of diseases modified by local conditions, he should be allowed to improve his knowledge and be of greater value to the people, and not be transferred just when he was getting familiar with the subject as was the case at present. It might be in the interests of the service to do so, but, it was highly detrimental to professional work. He attached to continuity of tenure very much more importance than is done at present. This would no doubt have the effect of placing certain officers in good places for a long time while keeping others in bad districts but that was inevitable.

The practical boycott of the Indian Medical Service in the medical schools at Home had commenced in the last 13 years.

By the remark, in his written statement, that every officer of the service, whether in military or civil, was made to feel that he was a member of the subordinate service, he did not mean to say subordinate to the Royal Army Medical Corps but simply that a member of the Indian Medical Service did not count for anything in the official world, in contradistinction to the importance of his help in times past.

In suggesting that the Director General, Indian Medical Service, should be Secretary to the Government of India and that the Surgeons-General and Inspectors-General of Civil Hospitals, should be Secretaries to their Governments, the underlying idea was that the medical service should be placed on terms of equality with other services, such as the Public Works Department, which had a member of the Department as Secretary to Government. To avoid the difficulty that these officers would have to be touring about, while Secretaries as a general rule do not go on tours, deputies could be appointed who could perform this function.

(General Hendley.) There should be no war reserve obtainable from the civil department. The late war had proved that satisfactory reserve could be had from private practitioners in India inasmuch as 800 young men had been forthcoming who had no preliminary training whatever. No doubt they were mostly from among inexperienced practitioners, but that was merely due to the fact that the whole idea was new and they had been given no training for this purpose. If they were recruited from the colleges at the proper time it would be possible to have a good war reserve. India was in no way inferior in medical enthusiasm to other parts of the British Empire but the only thing wanting was training. A war reserve in the future should not only be recruited from practitioners just fresh from college but also from the very best practitioners who had a good deal of experience. He was sure that experienced practitioners would be forthcoming and would be willing to give up their practice if they were given the chance of joining a special reserve such as prevailed in England. No doubt they did not do so as much as was expected in the recent war, but that was due to want of experience and training, and to their having been called on too suddenly. If it were made known that Government desired to form a reserve of such medical men, and would give them proper training, and grant them

17 March 1919.]

Colonel F. A. F. BARNARDO.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

army rank, it would be possible to get any number of practitioners to join it. If, however, experienced practitioners with 10 or 12 years' practice did not join, conscription could be introduced in their case. He was sure however, if a retaining fee were given, and proper position and rank were granted, experienced practitioners would be willing to give up their practice to go for military training simply for the glory of being attached to the army. The dearth of Indian private practitioners, in the late war, who were willing to go overseas, was due to the fact that this was the first time that they had been called on, and they had no guarantee that the conditions of service would be satisfactory. He felt it was possible to get anything you want out of India provided the proper training was given. The whole thing depended on the professors in the schools.

A war reserve of Royal Army Medical Corps officers might also be maintained in England. He was aware that in the early part of the war it was not India that drew upon England, but England that drew upon India. This was, however, due to the fact that the machinery at Home was not then complete. It would be well to note the peculiar qualifications or duties required of the military medical officer—

1. Prevention of disease and sanitation.
2. Evacuation of casualties from the front line to the lines of communication.
3. Care and treatment of casualties in hospitals.
4. Medical administration.

With regard to the prevention of disease, this was similar in principle to the duties of a sanitary officer of a municipality, with the only difference that he had to deal with large bodies of men rather than with sections of different communities. The second duty depended upon the temperament and pluck of the individual medical officer and does not depend upon training. His third duty was purely medical. For such work any civil medical practitioner dealing with the general public must make a better clinical medical officer than the army doctor who had experience only with healthy troops. Lastly his duties were in his capacity as an administrator. This was a life study and of the greatest importance. No special training was required for the first three of these duties. Three weeks would suffice to give all the training that was required, in fact three weeks' training would teach any person who had any idea of medicine all that was required in this direction. He did not therefore see any necessity for keeping a trained reserve. The military medical service officers would be quite sufficient for all the needs of India as they would provide the administrators who would then be surrounded by the war reserve appointed in case of emergency to duties to which they were best suited.

The statement made in his written statement to the effect that selection of the teaching staff in the medical schools was made by seniority, practically entirely, was based on his experience in Bengal. The professional staff was entirely composed of officers who were senior in service drawn from the provincial cadre and from civil surgeoncies. His remark applied to Bengal and he did not know whether it would apply to other provinces.

The remark in his written statement that "appointments are made and leave is granted by that member of the provincial government who includes the medical and sanitary service among the etcetra of his portfolio" referred only to Bengal. His experience was confined to that Presidency. No doubt the Surgeon-General could make a recommendation, but it might or might not be accepted by the Secretary in charge of the medical branch.

(General Hehir.) The amalgamation of the two military medical services proposed by him had already been going on for some years, as in both British station hospitals and Indian troops hospitals members of both the services had been working side by side for the last few years.

There were no advantages in having appointments in civil held by medical officers with military rank, but in order to hold his position in the district he should

rely on his professional ability and on the work that he could do. In fact, the holding of a military rank rather stood in the way of the civil surgeon, as it kept many people from approaching him, merely on account of the fact that he was a soldier. Many of the simple minded zemindars and other people kept away from him on that account alone.

He did not anticipate that, even if the War Office agreed to the unification of these two services, a highly efficient military medical service would be the result, unless the scheme he had suggested for the establishment of a military cadet college were adopted, and unless every officer in the military medical service were recognised by the remainder of the military staffs to not only be in the army but also of it, and unless his status was in no way inferior to that of any officer holding the same rank. He had been associated with the staff of the army for about five years, and would suggest that the smooth working was aimed at more from a military point of view than from the point of view of efficiency. It was very difficult to have an efficient military medical service which was practically in a mere subordinate position to the rest of the army. It was very difficult for an Indian Medical Service officer to get his work with other branches of the army through. He himself had been able to get everything he required because he happened to get on well personally with the General and others, but if this were not the case he would have been worse off compared with other officers of the army.

Officers in the other branches had some support and some standing and could rely on traditions in the army which the Indian Medical Service officers could not do. This applied especially to younger officers who had actually to do the work. He had served in South Africa and Somaliland and been to East Africa, and could say from experience that in the army the question of personality was of very great importance. Efficiency and smoothness should be legislated for by conditions and status of branches concerned and should not depend on personality.

The War Office would probably consent to the permanent transfer of say 200, and the seconding of 100 officers of the Royal Army Medical Corps to the Indian Medical Service.

The Indian Medical Service as at present constituted was capable of forming a Medical Corps for British and Indian troops; senior officers could step into British station hospitals and carry on the duties.

No reasonable pre-war arrangement for a war reserve would have been sufficient to meet the needs of the late war. The war reserve had proved adequate previous to the recent war because there had practically been no war before. It had, however, proved adequate for the smaller expeditions. The war reserve that there was, had been of great value in the early stages of mobilisation because the whole country was in a state of unpreparedness. The employment of a war reserve from the civil employ Indian Medical Service officers may be an economical arrangement, but it was not an efficient method of meeting medical needs in time of war.

No doubt some of the 800 practitioners who were taken to supplement the war reserve were those who had just passed their examinations and no doubt most of them joined to better their position and made no personal sacrifices.

With regard to the suggestion to transfer, in the late years of their service, senior medical officers, that is, those who were specialists, physicians and surgeons, to the military side, and to give them promotion and rank without passing them through the Assistant Director, Medical Services' mill, he was of opinion that they would be more efficient if they were employed in a professional capacity.

He advocated a purely civil medical service. This service could not possibly be unattractive to Britishers with the enormous field for practice and research which India afforded.

With regard to the question whether the present arrangement had not the advantage that an officer preferring the military side could get back to it,

17 March 1919.]

Colonel F. A. F. BARNARDO.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

he stated that there had not been a single case of an officer reverting to military of his own free will.

The civil side of the Indian Medical Service was short-handed and an increase in the civil cadre was called for, to provide for the larger number of civil surgeoncies which were necessary.

The leave reserve in both the civil and military sides had never been adequate.

Research work in India should be considerably expanded, and research institutes should be opened at several centres where the outbreak of disease or clinical material was the greatest. This work should, however, be under Imperial control.

There need be no apprehension about getting the very best graduates for the military side, whatever scheme was adopted. They should be selected by a competitive examination at Home. They must pass a preliminary examination to show that they were of a proper and suitable social standing. There should be a committee of the Board of Management of the school, that is, the Council of the School should make the selection. The examination should necessarily be held in England. He would not contemplate the holding of an examination in India at present, but there would be no objection to this when the standards of education in Indian medical colleges had been raised to a western standard. The holding of an examination at Home would not necessarily keep back any large number of poor students, as he believed really capable persons were not kept back on that score, as they could get some rich relatives to send them Home and support them there. The question of Government scholarships might be considered also.

It would be very useful to have an advisory board to assist the Director-General, Indian Medical Service, in making selection for professorial appointments. These appointments should be placed in one special cadre with their own special leave reserve.

He did not approve of the suggestion to revert officers from civil to military periodically, so that they might be able to have some military training. He did not see the necessity for military training, except for administration, and administration was a life work, and not a thing which could be learnt in two or three months. He would confine military training to the officers in permanent military employ whom it was intended to make administrators, and these should all be trained in the ordinary staff college work of the army.

There had been undue interference from Government with private practice among Indian Medical Service officers. Recent regulations had been often irritating though they had not really had very much ill effect, excepting that they foreboded further interference in the future.

The recent increase of 33 per cent. in emoluments of Indian Medical Service officers might prove attractive to a few mediocre officers, but it would have little effect in attracting the better type, as the real thing that detracted from the value of the Indian Medical Service was not the pay, but its loss of prestige.

This service was very much discredited in the medical schools in England. In 1913 when he went Home he had seen notices in the schools advising that no graduates should apply for admission to the Indian Medical Service until they had had a consultation with the Dean of the Faculty of Medicine.

Even if the causes of discontent explained in his written statement were removed, it would not be possible to restore the Indian Medical Service to its former popularity. The difficulty was to find out what were the real causes of discontent. The average Indian Medical Service officer would say that he did not get enough pay, enough leave, etc. It would, however, be impossible to restore the prestige of the services and the removal of the causes of discontent would not affect it. The whole thing depended on the prestige of the service, and if that were restored it would be accomplished.

The remark in his written statement to the effect that the underlying thought of every officer of the service was that he was made to feel, whether in military or civil employ, that he was a member of the

subordinate service, was based not only on his own experience, but it had been the unexpressed opinion of every member of the service he had come across. In justification of that it was simply to be pointed out that during the last 13 years not a single Indian Medical Service officer had sent up his son for the Indian Medical Service, while members of the other services such as the Army and Indian Civil Service frequently earmarked their sons to enter the service to which they belonged.

He could not go into details, and say whether the Surgeon-General had access to the Governor or not, and could only state the effect of the present arrangement. At present the Surgeon-General would write to an officer saying that he would be appointed to a certain district, and would then find that the Secretary or Member had promised the post to somebody else. He would then have to cancel his orders.

He approved of the conversion of the Indian Medical Service into a Corps with military assistant surgeons and sub-assistant surgeons.

He supported both the views put before the committee, one that military assistant surgeons should be abolished, and the second that their preliminary training should be improved. Military assistant surgeons were at present doing only the work of senior clerks. He had under him three military assistant surgeons, one of whom was drawing altogether Rs. 260 a month, including allowances, and was doing exactly the same class of work as was done by a clerk on Rs. 70. His position in the station hospital was exactly the same. He was not employed on professional work except at night. Military assistant surgeons were, however, a good class, and would, if trained, make good medical officers, though they would then cease to exist as assistant surgeons and would become officers.

He could not conceive of sub-assistant surgeons doing duty in British station hospitals as warrant officers. If a graduate was properly trained as a medical officer, he must be given the rank and position of a doctor, the essential condition being that the training must be good. Under the present conditions he would entirely stop the recruitment of military assistant surgeons and sub-assistant surgeons.

He was in favour of promotion examinations from captain to major and major to lieutenant-colonel.

He did not approve of the idea of establishing a military medical college in India for training Indian Medical Service officers and others.

With regard to the suggestion, that without radically altering the conditions of service, military assistant surgeons should be converted into a corps, and that a school might be established for this class of persons, he was of opinion that it would be very difficult to run the school with partially educated men. If it was desired to have military assistant surgeons, they must be taken from the medical colleges and they must be given military training.

The medical education at present given in India was good, though it fell short considerably in its appreciation of the ideals of western medicine.

(Major Cramer-Roberts.) In reply to the question whether he regarded the Indian Medical Service as purely civil employment or purely military he replied that it was military from the official point of view, but the only attraction which led men to join this service was the opportunity of going to the civil side. The late Sir Pardey Lukis had observed on one occasion that those who intended to go to civil were wasting their time by remaining in military, and the officer in civil employ regarded the officers who remained in military as those who had no interest in their profession.

The question of coming out to India as a private practitioner never came to his mind when he joined the Indian Medical Service. All its members joined the service with one object, namely that of going to the civil side. It would be extremely difficult to find an officer who joined the Indian Medical Service with the intention of remaining in military employ. If an officer were keen on staying in the army he would not have joined the Indian Medical Service at all, but would have gone to Sandhurst and joined the army direct.

17 March 1919.]

Colonel F. A. F. BARNARDO.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

(General Giffard.) There should be an absolutely independent Indian civil medical service. There should be in London one examination for the absolutely Indian civil medical service, one for the Royal Army Medical Corps and another for an Indian Army Medical Corps or Service. To induce students to join the Indian Army Medical Corps it would be well to hold out to them the bait that 10 per cent. or 5 per cent. of them could join civil employment by secondment. They alone of the men in civil employ might form the basis of a war reserve. He did not agree with the view that as there would be three services, namely the Royal Army Medical Corps, the Indian military medical service and the Indian civil medical service, competing for recruits, the military medical service would get the worst candidates, and was of opinion that 5 per cent. would form a considerable attraction as there was a large British community in India.

It would be possible for the committee to make such recommendations to the Government of India as would attract really good officers to the rejuvenated Indian Medical Service. It would be possible to do so by promising them civil employment. In that case they would not be disappointed as at present. All who at present joined the Indian Medical Service were disappointed in that on entering they were promised civil employment after two years' military employ, whereas, in actual practice, frequently ten years elapsed before an officer obtained the chance of going into civil.

He did not agree with the suggestion to have a single medical service for both military and civil duties, and to set up in India civil hospitals, station hospitals for sepoys and British, station hospitals for British troops in the same compound. The civil population could not be expected to come for treatment to a hospital where soldiers were being treated. It would not do to have men bringing their sick children to the same place where soldiers were being treated.

He was decidedly of opinion that the routine treatment of soldiers, either British or Indian in a civil hospital, or *vice versa*, was undesirable. There could be no objection to their treatment in a civil hospital if the transfer there was for better treatment.

The civil medical service should have no connection with the military, except that a certain excess number of military officers might be employed in civil.

(General Cree.) He had heard of the complaint in the *British Medical Journal* that an officer who, up to the rank of lieutenant-colonel, had devoted himself entirely to surgery or pathology or some special duty, had to revert to a military administrative appointment in order to get promotion above that rank. It would be useful to open the following three avenues to promotion :—

- (1) In the Indian Medical Service for a man who has been a specialist and has become a marked man as physician or surgeon, he might be allowed to continue in his special department getting promotion up to the highest rank with the pay and pension of his service as employed in the army, and by the civil as a consultant or specialist in his particular line.
- (2) That an officer should remain in civil, in charge of civil hospitals and so on, and get promotion up to the rank of colonel, and be employed in war time in base hospitals and on the lines of communications, and
- (3) That the officer who elected for a military career pure and simple should, when he reached the rank of lieutenant-colonel, fill important administrative appointments in the army and take a course in a staff college. It would be well to keep a specialist in his own line, and not to allow him to give it up to take up an administrative appointment. Of course for an officer who was to become a military administrative officer it would be of the greatest benefit that he should take a course of instruction in a staff college.

(General Hehir.) The suggestion to bring officers to civil from military was an impossible one. He could not understand how an officer like Sir Pardey Lukis could back up a scheme asking an officer in the middle of his military training to come to the civil side. It would also be useless to ask officers in civil employ to undergo military training.

18 March 1919.]

Mr. KAMAKSHI NATARAJAN.

*(The schemes and questions referred to by witnesses are contained in Volume III.)***At Bombay, Tuesday, 18th March 1919.**

PRESENT :

S. R. HIGNELL, Esq., C.I.E., I.C.S. (*Presiding.*)

MAJOR-GENERAL G. CREE, C.B., C.M.G., A.M.S.

MAJOR-GENERAL P. HEHIR, C.B., C.M.G., C.I.E.,
I.M.S.

MAJOR-GENERAL H. HENDLEY, K.H.S., I.M.S.

THE HON'BLE MAJOR-GENERAL G. G. GIFFARD,
C.S.I., I.M.S.LIEUTENANT-COLONEL A. SHAIRP, C.M.G., Indian
Army.MAJOR M. T. CRAMER-ROBERTS, D.S.O., Indian
Army.and, as co-opted members SIR T. NARIMAN, Kt., the HON'BLE COLONEL H. E. BANATVALA, C.S.I., I.M.S., and
LIEUTENANT-COLONEL BHOLA NAUTH, C.I.E., I.M.S.MAJOR A. A. MCNEIGHT, I.M.S. (*Secretary.*)MR. KAMAKSHI NATARAJAN, B.A., Editor of the Indian Social Reformer, Ordinary Fellow and Member of the
Syndicate of the Bombay University, Member, Municipal Council, Bandra, Thana district, etc.*Written statement.*

(1) Of the schemes attached to the invitation to give evidence before this Committee, scheme D comes nearest to what in my view would be the most suitable scheme of a medical service for India. Scheme A is in most other respects identical with scheme D, but while it seeks to make the Indian service an auxiliary to the Royal Army Medical Corps, scheme D rightly insists that the Indian Army Medical Corps shall consist of officers recruited entirely for the service in India with a proportion of officers of the Royal Army Medical Corps as auxiliaries. India is too big a concern to be treated as a side issue.

Even scheme D, however, falls short of Indian requirements in some important respects. It lays down that entrance to the Indian Army Medical Corps, otherwise than by transfer from the Royal Army Medical Corps, shall be obtained by open competitive examination in the United Kingdom. I think there ought to be a simultaneous examination in India for the purpose, with the same standard and the same set of papers, and valued by the same examiners. Candidates who pass the examination in India may be sent to England for further training. To send prospective candidates on scholarships to England is not a satisfactory way : first, because only a few scholarships can be given, and those who avail themselves of it, may not be the best men in the country; and, secondly, because it is unfair to make a sea-voyage of several thousands of miles and residence in a foreign land a condition precedent merely to being allowed to appear at an examination which is supposed to be one of open competition. In order to ensure the admission of a due proportion of candidates educated and recruited in England, the proportion to be recruited in India may be limited to 50 per cent. of the number required every year.

It is not expressly stated in the scheme that the open competition for admission to the civil medical service should also be exclusively in England, but that seems to be implied. The proposal I have made for recruitment to the Indian Medical Corps applies with even greater force to the civil medical service. I would put the proportion to be recruited in India of the latter service at three-fourths of the annual requirements. Whatever may be the case as regard the Indian Civil Service, there can be no two opinions as to Indian medical men being more suited to work among the people of India than non-Indians.

There is one reservation, however. When I speak of the annual requirements of the civil medical service,

I mean what may be called the general branch of that service including civil surgeoncies, jails, sanitary branches, chemical and bacteriological analysis, and so on.

There should be an independent educational (including research) section to which selection should be made with the assistance of an Advisory Board. These appointments should be open to medical scientists throughout the British Empire, and the best men should be chosen. The appointments should be for a period of not more than 5 years at a time, and no private practice should be allowed. The scale of salaries should be fixed at a sufficiently high level to attract first-class scientific men, in view of these two limitations.

The Education (and Research) Branch should be managed by the Universities. It should be the object of this branch to raise the standard of medical education in India to a level with that of the advanced countries of the west.

10 per cent. of the appointments in what I have called the general branch of the civil medical service should be reserved for assistant surgeons of exceptional merit. These men should be selected from among those who have put in not less than 5 years' and not more than 10 years' service. They should be sent for a course of post-graduate training.

I strongly support the suggestion that there should be established an Indian Medical Corps College, and members of the civil medical service should go through a course in it. I also approve of the suggestion that at the end of each succeeding 5 years civil medical officers should go through a six months' duty at a station hospital.

(2) Scheme (D) modified as suggested above will, I think, attract a good stamp of recruits and meet the demands of professional opinion in India. I do not know about England, but I do not see why the modifications suggested by me should make it less acceptable to English candidates and professional opinion than it would be without them. If the scheme fails in either respect, the whole subject will have to be reconsidered.

(3) Scheme (D) modified as I have suggested will, I think, meet the civil requirements very well. In the case of war on a large scale, these will be less detrimentally affected than during the late war. On the contrary, the civil administration will be free to develop and supply its requirements unhampered, while, at the same time, owing to the compulsory military training prescribed, the medical reserve for the army will also grow with the growth of the civil medical service.

18 March 1919.]

MR. KAMAKSHI NATARAJAN.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

(4) The present standard of medical education required for the Indian Medical Service seems to be satisfactory.

(5) As regard study leave, I agree with the recommendation of the Public Services Commission in paragraph 30 of the annexure to their report on the medical

services, with the proviso that the officers of the Educational and Research Branch should be given greater facilities and at shorter intervals than those of the general branch.

(6) This has already been answered.

MR. KAMAKSHI NATARAJAN, called and examined.

(Mr. Hignell.) He objected for two reasons to the proposal to send Indian students to England with scholarships only to appear at a competitive examination to be held there for the Indian Army Medical Corps and civil medical service as outlined in scheme D. In the first place many Indians could not be sent to England with scholarships and in the second place, they might pass or fail. They were only taking a chance. Whereas if a simultaneous examination was held in India and the selected candidates were sent to England for a period of two years for further training, it would be more fair to Indians, and that was the principle laid down in the Montagu-Chelmsford Report.

Speaking as a non-official Indian, he said that there would be no danger of Indians who had got into the service through the examination held in India being regarded as inferior by those who came out successful in the examination held in England, but that it all depended upon the character of the men concerned. He was taking his stand upon the fact that Mr. Montagu and Lord Chelmsford had agreed that the practice of having an examination only in England was unfair to Indians, and that a scheme should be devised by which Indians could be recruited in India and then sent Home for the completion of their education there.

(Sir T. Nariman.) He did not anticipate any difficulty in arranging for the practical part of the simultaneous examination which would be identical with that held in England. If practical and oral examinations could be held in the case of the Indian Civil Service, he did not see why it could not be done in the case of the medical service. The same English examiners might be asked to come to India to examine Indian candidates and a big laboratory also could be built at Delhi. He did not desire that the standard should be lowered in the least, but only pleaded for fair play for Indians.

(Mr. Hignell.) When asked to explain what he meant by the expression "the Education (and Research) Branch should be managed by the Universities," he said that the professors appointed to do research work, should not belong to the administrative branch, but to the academical side of the service, that is, they must be attached to the University as ordinary University professors. The Government of India would, of course, have to nominate these research scholars with the help of an Advisory Board, but after the appointment was definitely made, the professors should form part of the University of the province to which they would be posted, though their pay and pension would be borne by Government.

In the first place, research professors should be appointed only for five years; but there was no objection to their renomination after the end of that period provided that they had proved successful.

As regards "study leave," he explained that these research professors should be allowed, during vacations, which lasted about three months a year, to proceed to Europe on their full pay and allowances in order that they might be in touch with the latest developments in

Europe. Further, they might, in addition, be given six months' "study leave" during their five years, if it was found necessary. The medical education imparted in this country should be improved, as soon as possible and for that purpose he would get the best men and pay them the highest salaries which India could afford.

(General Hendley.) It would be difficult to get really good men for research work if the appointment was only for five years and if they were not allowed private practice, and that was the reason why he had suggested that these professors should be paid at a special rate. He would be willing to pay them the salary of a Member of Council if they were really good men.

All research appointments should be open to all medical scientists throughout the British Empire. The same remark would apply in the case of all professorial appointments. He attached the greatest importance to professors who really came in contact with students. He would take away all the professorial appointments from the cadre of the Indian Medical Service and throw them open to all scientists in the British Empire. He would not even bar colonials from the professorial appointments in Indian colleges.

(General Hehir.) Selection for the Indian Army Medical Corps and also for the Civil Medical Service should be made by open competitive examination; but before sitting for the examination, candidates must be asked to produce certificates of good conduct and good health.

(Lieutenant-Colonel Bhola Nath.) He desired that the Indian element should predominate in the Civil Medical Service. As the successful candidates at the competitive examination would be sent to England for a further training, he thought that they would be as good as British officers. He was strongly opposed to any restriction which would limit admission to the service to men of good caste.

(Colonel Banatvala.) While the Indian candidates were undergoing training in England for two years, the English candidates would undergo training in India, as a good knowledge of the country in which they were to serve was essential for them.

(General Giffard.) To ask Indians to go all the way to England simply to appear at a competitive examination there was unfair. He did not want to exclude Englishmen from the service. There was always need for Englishmen of the best type in India. He only wanted Indians to be given fair play.

In his written statement, he had said that only 10 per cent. of the Civil Medical Service should be reserved for civil assistant surgeons, in order that there might be some incentive for them to work. The proportion should not, however, be raised as those who had risen from the position of subordinates often had not the necessary initiative, independence and self-consciousness of those who were recruited directly to the service.

(General Cree.) He thought that the Indian Army Medical Corps reorganised on the lines he had suggested would be able to look after British troops also.

MAJOR W. S. J. SHAW, M.D., I.M.S., Superintendent, Central Lunatic Asylum, Yeravda, Poona.

Written statement.

Questions for witnesses.

1. Defects in organisation noticed—

(a) R. A. M. C.—It is hardly possible to compare the present Royal Army Medical Corps with the Royal Army Medical Corps of pre-war days. The great temporary

influx of the civil general practitioner and consultant specialist has distorted it so greatly that it can hardly be considered the same service. In my experience specialism is overdone, ordinary every day cases being handed over to specialists for treatment. The fact that

18 March 1919.]

Major W. S. J. SHAW.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

the strength of the corps has to be kept at a higher average than is necessary for local requirements unduly lessens individual work. These conditions must operate in lessening experience and self-reliance. Royal Army Medical Corps officers, dealing only with British troops are completely out of touch with Indians, and have little dealing with them professionally, officially, or socially. Further, except in rare instances the treatment of the sick in India cannot be carried out as satisfactorily by officers who are temporary visitors to the tropics, as it can by officers who permanently reside in India.

(b) I. M. S.—The disjointed regimental hospital system is bad and these hospitals give little professional work and are poorly equipped. The station hospital system should improve matters, and the larger the station hospital (within limits) the better.

The Indian Medical Service has also been distorted to some extent during the war by the influx of a very large number of temporary officers of Indian nationality. As these are nearly all of junior rank, their temporary absorption in the service has not, as far as I know, influenced in any way the routine of work and promotion among the regular officers. Should, however, any large number of these receive permanent commissions "en bloc" the fact must constitute a block to European recruitment in the future.

Pay has up to date been inadequate, expenses have increased greatly in the last twenty years, and private practice has almost disappeared, through no fault, but rather owing to the good work of the Indian Medical Service.

I have always experienced great difficulty in getting leave, owing to there being no one available to take my place. I think this is an admitted general defect in Indian Medical Service organisation.

The fact that the heads of the civil medical department in India and in each province have not been Secretaries to their local governments up to date, in my opinion, has militated against progress, and the fact that Indian Medical Service officers have been excluded from the post of Director, Medical Services, India, has been a definite slur on the service, as suggestive of incapacity.

The chief essential of any scheme which would commend itself to me is the organisation in one service of the military and civil branches of the medical service of India.

For this reason mainly, schemes B and C commend themselves. The former, however, can hardly be considered a complete scheme, though, it is admirably suggestive, and the latter which resembles B closely, is wanting in detail especially as regards the civil side of the service. An important defect in both is that new and higher rates of pay are not suggested than those at present obtaining.

Scheme A is not worthy of consideration. It does not make for unification, and suggests what must be in effect a subordinate service for Indians and Anglo-Indians—which is impossible. The "points of the scheme" are contrary to all facts.

Scheme D prescribes quite distinct military and civil medical services. I consider this a cardinal defect, as civil employment for military medical officers is designed to supply specialists and consultants to the army in war (and peace), to afford employment to military medical officers whose services are unnecessary with the army in peace time, and to further the general efficiency of the officers in the various branches of professional work and general administration.

If it is necessary to select one scheme, I consider scheme C the most acceptable, in that it provides one medical service for India. Its paragraph 2 is doubtfully worded, but I think that it may be read as providing a military and a civil branch of the proposed Indian Medical Service (or corps). It also appears to me to provide a workable method of dealing with present conditions, and those of the near future; and if adequate pay is given, I see no reason why it should not

attract the best men in the schools at Home, as the Indian Medical Service has done in the past.

I consider, however, that the scheme should contain a provision for the completion of the education of Indian candidates such as is outlined in scheme B, paragraph 6.

With reference to paragraph 38, I consider that if adequate facilities be given, the civil medical service should contain sufficient consultants and specialists for ordinary purposes. The existing branches of the civil medical department, and a properly organised alienist department, with certain few experts recruited perhaps at Home, should suffice to meet all eventualities.

I do not see that the inclusion of combatant officers in the proposed "promotion board" (paragraph 27) can serve any useful purpose and I am certain that it would be a mistake.

I do not see why Indians whose qualifications are registrable in England should not be eligible to compete for the service, but a definite period of study and practical and social training at Home should be a *sine qua non* prior to the entrance examination.

2. Yes. I consider that it should fulfil both conditions, with the reservations made above.

3. The scheme should attract, if pay is sufficient. Pay is at present lower in the Indian Medical Service than in any other branch of the Indian Army, whereas it should be higher. It should be borne in mind that professional prospects have improved greatly at Home, and that salaries in medical appointments there, have doubled within the last twenty years.

4. I consider that the knowledge of war conditions and the determination to "stick it out" have stifled objections among European residents. On the whole, I consider that the quality of the work suffered by the withdrawal.

5. I think, that the scheme should meet the needs of the civil administration in India. An officer will not, however, be likely to enter civil employ, unless his salary is at least on a par with the salaries of officers in the other civil departments in his station; age and length of service being considered.

This could, of course, be arranged by means of "allowances" attached to the post held by the officer and should leave out of consideration fees for professional practice. Paragraph 45 does not, I think, sufficiently provide for this.

The question of "residuary" or "indispensable" appointments (paragraph 31) calls for consideration here. In a properly organised service the appointment may be indispensable, but the individual should not be so, in a rigid sense. The most indispensable officers in this sense are heads of departments. Individual specialists, for instance during a great war, may be considered "indispensable," but each such officer should be informed that his appointment is a "residuary" one before he takes it, as he is practically cut off from any chance of special promotion or distinction by his acceptance of it.

I presume that, though the fact is not clearly stated, the proposed civil medical service would include all branches which are now held by the Indian Medical Service in the Sanitary, Jail, Bacteriological and Chemical Departments as well as a properly organised Alienist Department.

War, on a large scale, must affect the civil personnel if that personnel is available as a war reserve. I consider that scheme C envisages a better war reserve than does any other submitted. A very great war might, of course, involve the Royal Army Medical Corps and its reserve.

6. Replied to under 5.

7. Yes. The scheme provides a large war reserve as it aims at securing all medical men available in some capacity, and giving them a sufficient military medical training. Absentees, and those on the suggested Home reserve could be rapidly called up, if required.

8. I should think that the Indian Medical Service reserve (civil side) has been most valuable during the war.

18 March 1919.]

Major W. S. J. SHAW.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

9. Scheme C includes suggestions regarding recruitment and education. Indian aspirations should be satisfied by the method suggested in scheme B, paragraph 6.

10. I consider that the present period of study leave available is ample, but that the period should count as duty and not leave at Home, and passage be granted at the public expense.

11. Research is necessary in each branch of medical science. I am doubtful if a single department could be organised to carry out research in different subjects. Research should be encouraged in each department of medical activity.

12. Private practice has almost disappeared, in fact no regular income can be counted on from this source, except in a few appointments in the large cities.

This is owing to the growth of an independent medical profession in India, and is due mainly to the activities of the Indian Medical Service as an educative factor. Further, transfers of officers from station to station must operate by lessening individual practice. Practice must accrue to resident medical men. Some consultant practice remains, but almost purely for specialists in certain subjects. The restrictions on private practice made by Government, in my opinion, helped to spread and encouraged the idea that ordinary fees were excessive.

Questions to be asked of service officers.

1. I have been four years in military and nearly fifteen years in civil service.

2. As have already stated, I consider that pay and leave in the service is not sufficient. As a parallel regarding pay I would point out that the superintendent of an asylum in England draws as high (or higher) a rate of pay as does one in India. The conditions and amenities of life are not comparable in the two countries and when the expenses of passage, etc., are considered the Indian appointment is very distinctly the worse. In addition the pension of the superintendent in England is a very good one and he has not had to spend his life in the tropics.

I would here draw attention to the defects of the so-called Alienist Department in India, and I know that my views are shared by the other officers of the department, and have been agreed in by every senior officer in the Indian Medical Service with whom I am acquainted:—

- (a) To begin with the Alienist Department is not properly speaking a department at all. It is inchoate, a haphazard group of officers, with no directorate. There are six central asylums in India each managed before the war by a "specialist" whole time superintendent. There are also fourteen district asylums in charge of civil surgeons in addition to their ordinary work. These latter officers have no special knowledge of psychiatry and are liable to frequent transfer.

The only inspecting officers of these two types of asylums are the heads of the provincial (civil) medical service, i.e., the Surgeon-General with the local government or the Inspector-General of Civil Hospitals of the province. I have never yet met one of these officers, who felt satisfied with his capacity to properly inspect an asylum managed by a specialist, and I think most would be glad not to have to do it.

I submit that the position of such officers is very difficult, and further that their inspection of district asylums can serve no very obvious purpose if there is to be any progress in the treatment of the insane in India. I think, I am right in making the statement that the management of asylums by non-specialists is a system peculiar to India.

- (b) The asylums of India cater for a minute proportion of the insane population of India. I went into this subject (among others in connection with the department) in a memorandum addressed to the Director-General, Indian

Medical Service (my confidential no. 618, dated the 4th April 1918), and the arguments, etc., are too lengthy for detail here. The census returns are obviously and ridiculously wrong regarding the incidence of insanity in India, and I do not consider that they show one-tenth of the total.

- (c) In 1906, when I joined the Alienist Department I was told by the Director-General, Indian Medical Service, that it was to be a proper department—Indian or provincial to be decided later—under its own head. It has not been so organised up to date. I was told then that district asylums were to be done away with as soon as the central ones could be constructed, it being admitted then that specialist management was a necessity.

- (d) In all other countries that I know of a system of inspection of asylums by experts exists. That in England is well known, being both medical and legal. In Australia and South Africa expert inspection is established, and in Egypt where general conditions and the types of patients approximate those obtaining in India, the lunacy department is a definite branch of the ministry of the interior and is under the direction of a specialist medical officer who is termed the Director of the Lunacy Division. This method of administration has been found necessary in Egypt where there are three asylums in all and where the total population is a little over half that of Bombay Presidency.

- (e) In all other civilized countries either the name "Lunatic Asylum" has been abandoned, or the view has been clearly taken that such institutions are hospitals for persons suffering from mental disease. This view has not been adopted in India yet. I consider that it is established by the continued existence of "district" asylums side by side with those managed by "specialists." In addition I may mention that an order of Government exists in which it is stated that "persons suffering from the temporary results of sickness, intemperance and debauchery and those whose friends ought to support them should be kept out of public asylums" and also that "asylums should be reserved only for criminal lunatics, lunatics who are absolutely dangerous, and those who having no friends or belongings may be in the acute stage in which there is most hope of medical treatment." Magistrates, I presume, act on this order. At the same time Act IV of 1912 (paragraphs 4 to 11) suggests the conception of an asylum as a hospital for mental disease. Up to 1912 lunacy administration in India was governed by Act XXXVI of 1858.

- (f) I am of opinion that only officers who have had good experience as assistant medical officers of home asylums should be considered suitable for superintendencies of central asylums in India. The mere possession of academic qualifications, though desirable, should not qualify for such appointments in the absence of evidence of practical and administrative capacity. I consider that if such officers are not available in the service they should be obtained from the home asylums on special terms, and I was told by the Director-General in 1906 that this was to be the procedure.

- (g) A great deal of money has been wasted in India on unsuitable asylum construction in the past, and I know of no asylum in India that has been designed by any one with a knowledge of asylum construction, with the possible exception of that at Ranchi which I have not seen. It is, I think, obvious that no specialist's opinion should be taken alone

18 March 1919.]

Major W. S. J. SHAW.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

as to the construction of such institutions unless he has had long experience of practical administration. The establishment of a Directorate in the Department should obviate or appreciably tend to lessen the probability of loss by faulty or unduly expensive construction. As the generally admitted backwardness of Indian asylums as hospitals for the treatment of mental disease must be traced to the system of management and supervision, hitherto adopted, I submit that it is time that system were improved. Psychiatry is perhaps the most distinct specialist that exists in the medical profession, and this fact is, I think, thoroughly recognised all over the world.

- (h) The specialist asylum superintendent in India is greatly overworked under present conditions. His professional work is almost entirely personal, he has no trained assistance in it, and the business work of the large institution is also his to oversee and be responsible for. The most ordinary means of the treatment of the insane in Europe are still in India conspicuous by their absence, and only so, apparently, because they have not been used in India in the past. Though the science of psychiatry has advanced greatly in Europe during the past thirty years' the system of the management and treatment of the insane in India has remained stationary except for the introduction of a few specialist superintendents since 1906 and the Lunacy Act (IV of 1912). It is probable, however, that any development during recent years has been stopped by the war. If the Department is properly organised as suggested, I consider that the superintendents of central asylums in India would naturally be consultants to the military hospitals in their vicinity.

- (i) Asylum Superintendents have up to date been "nobody's children." Where one of our present controlling officers takes a special and professional interest in asylums and the treatment of mental disease, another takes little or none and patients and superintendent suffer accordingly. I submit that, if specialists in psychiatry are to superintend asylums, they should be given every facility for the carrying out of their work and also that a system of supervision should be inaugurated soon to control faddism or freakishness in a satisfactory manner and put up to the authorities the real needs of the Department, and regulate its proper requirements as to staff, etc.

I, therefore, consider that a Directorate of some sort within the Department is necessary. This presumably would be for India as a whole at first on account of the small number of existing asylums, but it is certain to become provincial eventually as the number of asylums must increase considerably.

In the memorandum to the Director-General to which I have referred, I have dealt with this subject fairly fully.

3. No.
4. Only those already suggested.
5. (a) Five years at a time.
- (b) Six months at a time.

I regret that as I only received the necessary papers on March 8, owing to my temporary absence on deputation to Burma, I have not been able to deal with the various questions as fully as I otherwise might have done. As regards the Alienist Department, I have felt it my duty to put forward the subject on behalf of my fellow superintendents and our patients.

MAJOR SHAW, called and examined.

(Mr. Hignell.) He was not in favour of a separation of the two services—civil and military. He thought they ought to remain together.

With regard to the Alienist Department, he had submitted a memorandum on this subject to the Director-General, Indian Medical Service, in April 1918, and he was informed in reply that nothing could be done till after the war. A copy of this memorandum was with the Surgeon-General of Bombay. In his opinion the Alienist Department was nobody's child.

(General Hendley.) In the past officers from the Indian Medical Service had been put into the Alienist Department but personally he would like to have in the Department officers who had had previous experience in this sort of work, preferably in English asylums. He was supposed to be qualified and he was asked to join the department in 1906. He was told that in the event of his refusing to join he would go down to the bottom of the list, and officers from the Home service would be brought out. He had been in the Department ever since. Hitherto, no officers had been brought out from England. He thought it was necessary that officers should study the subject in England before being drafted into the Alienist Department. He knew of an Indian Medical Service officer who had spent his study leave in studying the subject. The Alienist Department should be a separate branch of the service and have a Director of its own. The Director should be one with experience in the country. There was plenty of room for expansion in the Alienist Department. The normal population of the Yeravda Asylum was 426. This number had been increased to 1,000, and two more asylums were being built to accommodate 1,000 each. He was not able to say what would be the ultimate needs of the Bombay Presidency for qualified alienists. He could not agree with the census returns regarding the incidence of insanity in India. In his

opinion there were more deaf mutes than lunatics in the province. There ought to be two qualified alienists in every asylum containing 1,000 lunatics. At present when he went away there was nobody to look after them, except a military sub-assistant surgeon, and he had no experience at all. He thought that Indians would do very well if they took up the study of lunacy. At present, for some reason or other, the Indian did not fancy the Alienist Department. The military assistant surgeons who were attached to asylums had no application for this sort of work at all. Since the war he had had to dismiss two for drunkenness.

(General Hehir.) The charge of district asylums by district surgeons was unsatisfactory as these officers knew very little about lunatics. At present an officer who wished to enter the Alienist Department had to apply to the Director-General, Indian Medical Service, sending in his qualifications. Most officers who entered the department were admitted in it on the ground that they held certificates granted by the Medical Psychological Society. He agreed with the suggestion that it would be a good thing to attach junior officers to the larger central asylums for periods of probation. There were not enough experts in the Alienist Department, with the result that when any of its members went on leave there was nobody to replace them.

The asylums in India had been badly constructed. They were certainly not constructed by one with a knowledge of asylums. He had not seen the Ranchi asylum and, therefore, could not say how it was constructed.

He advised the appointment of a Director for the Alienist Department. This officer should carry out the inspectional work and be generally connected with the administration of asylums. He was opposed to the term "Superintendent" being replaced by that of "Governor." The latter term was usually applied to officers in

18 March 1919.]

Major W. S. J. SHAW.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

charge of jails. The asylums at present were under provincial control and not under the Government of India. If there was no officer, suitable to fill a vacancy as superintendent of an asylum, available from the provincial cadre of Indian Medical Service officers, the Government of India selected and appointed an officer.

The lunatics in his asylum included European (both civil and military), Anglo-Indians and Parsis. He usually received all European insanes that had to be sent to England.

He considered that the pre-war leave reserve was inadequate. He never could get leave at all. He was of opinion that the Indian Medical Service had suffered to a certain extent by the fact that the Director, Medical Services, was chosen from the British service. This fact had given the impression that the Indian Medical Service was inferior to the Royal Army Medical Corps.

If the main causes of discontent in the Indian Medical Service were removed the introduction of scheme C would solve the problem.

(Sir T. Nariman.) He favoured the idea of attaching junior officers to lunatic asylums for the purpose of undergoing a six months' course of training, but he did not think that this period would make them expert alienists.

He considered it very essential that all Indian trained students competing for the Indian Medical Service should after they had passed an examination in India undergo a further course of social and practical training in England prior to their admittance into the Indian Medical Service.

(Major Cramer-Roberts.) He considered that the present period of study leave was adequate but suggested

that the period should count as duty and not leave in England.

(General Giffard.) He wished to keep both the civil and military service together. He feared that there would be friction if there were two separate services.

If recruitment were carried out for the Royal Army Medical Corps the Indian military medical corps and the Indian civil medical service, and the pay in each of the services was approximately the same, the civil medical service would get the worst men, for the reason that there was very little private practice at the present time. If, on the other hand, the prospects of private practice were good, the civil medical service would get all the best men, and the Indian military service the worst.

He would as far as possible keep the Indian department inside the Indian Medical Service. It would be hard to keep a cadre that would give leave vacancies unless there were two and three officers to each asylum. He would very much like the Government to start a separate Indian Alienist Department.

Graduates of the Indian medical schools and colleges had not yet taken up alienist work, for the simple reason that it was not made worth their while. The department was too small and the only appointments that were available were open only to military assistant surgeons. The Indian Alienist Department could not be managed entirely by Indians. There should be a European officer in every central asylum for the purpose of treating Europeans. A European patient could not conveniently be looked after by an Indian doctor.

If the Indian Medical Service were increased in size they could take over the care of both British and Indian troops.

MAJOR W. TARR, M.D., F.R.C.S., I.M.S., Civil Surgeon, Jubbulpore.

Written statement.

Questions for witnesses.

1. I favour scheme B because, (a) it is a compromise and will probably be less difficult to work than an entirely new scheme.

(b) It makes provision for the Director, Medical Services, to be selected from the Indian Medical Service, thereby removing a legitimate grievance.

(c) It makes provision for an advisory board and a medical staff college.

(d) It abolishes the area allotment, which in these days is an absurd arrangement.

2. It should meet with the approval of the War Office and will meet the needs of the army in India.

3. I cannot say. So much depends on the status of medical men under the State medical service in England.

4. I don't know.

5. It will meet with the present needs of the civil administration. In case of war there would be less dislocation owing to the increase in the cadre.

6. I think it would give an efficient reserve, but not sufficient; private practitioners, who are yearly increasing in numbers, should be enrolled in case of a big war.

7. A medical service reserve for war, previously trained in military duties is an advantage but not a necessity. The reserve should be in India.

8. The members were put into every kind of military billet there was in the medical department and the instances in which they failed were very few.

9. Recruits should have a European training; the system at present in force is sufficient.

10. Study leave should be compulsory, at least six months should have to be done at post-graduate courses twice in the course of the first twenty years.

11. Any person selected for the research department should be on "probation" the first year, so that he could be reverted, in case there was want of aptitude for that kind of work.

12. Private practice has declined and must eventually disappear, except for consulting practice.

The reasons are (1) the growth of the independent medical profession, (2) the large increase in the amount of work a man in civil has to perform, giving him less and less time for other than government work, (3) too frequent changes of officers.

Questions to be asked of service officers.

1. Seven years in military,—eight in civil.

2. I have not been sufficiently well paid for the responsibilities I have had to undertake. I have been unable to get more than nine months' furlough.

3. I have met with no instance of friction between Royal Army Medical Corps and Indian Medical Service.

4. That the Director, Medical Services, be alternately Royal Army Medical Corps and Indian Medical Service. That passages Home be paid by Government. That the Indian Medical Service get promotion to lieutenant-colonel at the same length of service as Royal Army Medical Corps.

5. (a) After 3 years.

(b) After 18 years.

Questions to be asked of officers regarding assistant surgeons and sub-assistant surgeons.

3. Pay should start at Rs. 50 and rise to Rs. 150.

4. There are not enough in either branch when all are here. None can be spared from present number without serious dislocation of work. Number should be increased. The larger outlying dispensaries should have assistant surgeons instead of sub-assistant surgeons. For peripatetic work 2 to 6 sub-assistant surgeons in each district could be usefully employed. There was dislocation. I cannot say how much.

5. Unless the civil assistant surgeon branch is made more attractive it is undesirable to make them liable for military service.

6. At present medical aid is only available at headquarters of districts and tahsils; the majority of the population is still unprovided for.

18 March 1919.]

Major W. TARR.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

10. In case of war I think they could form a war reserve just as the Indian Medical Service does now.

Special questions.

1. I think the Europeans referred to pay little heed to racial consideration; when they are themselves ill, they are "entitled" persons and except for a case requiring consultation are content to be doctored by the prescribed medical man; when their families are ill, and they have to pay, they call in a man educated entirely at Home, if they can get him, because they consider his training has been more thorough and that he is probably a more able man.

2. Europeans have not been satisfied with Indian substitutes. In this area, when they have anything serious the matter with themselves or their families, they arrange if possible to come to a centre where they can consult an European, or ask him to come to them.

3. The average sub-assistant surgeon in civil is inefficient and becomes more so with length of service.

The average civil assistant surgeon tends to improve with years and is efficient. The average Indian in the Indian Medical Service does not trouble to keep abreast of the times. I cannot say if there has been any change in recent years.

Medical Store Department.

1. (a) Principally from Ferris & Co., Bristol, and Down Brothers, London.

(b) Firms in Calcutta and Bombay.

2. Responsibility rests with Inspector-General of Civil Hospitals. The suggestion of having Government Medical Stores as sources of supply is obviously sound.

Increased manufacture in India should be easily arranged.

3. No.

MAJOR W. TARR, called and examined.

(Mr. Hignell.) He was in favour of scheme B. He thought that the Indian Medical Service could take over the whole of the medical services of India including charge of British troops, and that it was only a matter of numbers.

He was on military duty during all the time the war was in progress and he came back to civil only after the war had ended.

Government should provide free passages to England for Indian Medical Service officers and their families once every five years.

He did not think very highly of sub-assistant surgeons as a class, but they were very useful men and their training should be improved. It seemed to him that the majority of sub-assistant surgeons deteriorated as they advanced in years, because as a rule they were far away from headquarters. Civil assistant surgeons, on the other hand, became more efficient with years, because they were always near headquarters.

He was in favour of a scheme of divisional hospitals, the utility of which depended, in his opinion, more on means of communication.

(General Giffard.) A war reserve of medical officers previously trained in military duties, would be an advantage, but not a necessity. The advantage was that, if they were asked suddenly to take charge of a military hospital, or placed in any other position which required some disciplinary training, they would have the necessary training.

He would not make it compulsory for all civil assistant surgeons to go through a military training. Such training should be optional. The same privilege of

volunteering might be extended to sub-assistant surgeons also.

As an incentive to volunteering they might be given some permanent increase in their pay both in the case of assistant and sub-assistant surgeons. Civil assistant surgeons should be given at least an increase of Rs. 50 per mensem; but he had not thought about sub-assistant surgeons.

He thought that the civil medical service should form a reserve for military, otherwise there was no reserve in India.

(Colonel Banatrala.) When asked to explain what he meant by the expression "recruits should have a European training, the system at present in force is sufficient," he said that he referred to the system of examinations at present in vogue. He would not insist on candidates for the Indian Medical Service going through their whole medical course in England but would prefer them to finish their education there.

(General Hehir.) He was in favour of increasing the number of civil surgeons, and civil assistant surgeons, and still more the number of civil sub-assistant surgeons. He thought that the civil medical service should form a war reserve. He had not given much thought to the question of simultaneous examination in India. He was of opinion that it would be advantageous for Indians to get a training in England before getting into the Indian Medical Service, as the schools in India had not sufficiently developed. He would prefer that promotion to lieutenant-colonel should be made by selection, if that were possible.

He was in favour of promotion examinations from captain to major and from major to lieutenant-colonel.

Civil Assistant Surgeon W. V. KANE, B.A., L.M. & S., Civil Surgeon, Nimar, Central Provinces.

Written statement.

Questions for civil assistant surgeons.

1. No definite opinion on this question could be given as it will depend on individual circumstances. I am, however, inclined to think that most of our class would be prepared to serve with Indian troops or in Indian station hospitals if such service is asked of them only within the first few years of their service, provided also that the total period of such service is not more than three years and that it is not continuous but broken into different periods.

2. No, not quite. The present pension rules for civil assistant surgeons are similar to those obtaining for other provincial services but in consideration of the fact that the medical man cannot take advantage of Sundays and other holidays the following modification in the rules is suggested, i.e., that the qualifying service for retiring pension should be 25 years instead of 30 as at present. Another un-

satisfactory feature of the rules is that no provision is made for either gratuity or pension to widows and orphans of the civil assistant surgeons who may happen to die either of any accident or of infectious disease contracted in the discharge of his public duties. A provision to this effect is worth consideration.

3. The provision made by Government for the pension of the widows and orphans of the military assistant surgeons is in my opinion fairly satisfactory. I cannot give an opinion as regards the provision made by the military assistant surgeons themselves as I have no personal knowledge of any such arrangements.

4. The following are some of the disabilities in the department requiring the attention of the Committee:—

1. Grade examinations as they do not serve the object for which they were intended (i.e.,

18 March 1919.]

Civil Assistant Surgeon W. V. KANE.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

- to keep the knowledge up-to-date) and as they are inelastic in their operations, should be abolished and a post-graduate course say 3 months in every 5 years in any of the approved medical colleges be introduced in its stead.
2. Study leave up to about 12 months for obtaining higher qualifications either in India or abroad may be granted.
 3. Privilege leave of about 2 months in a year accumulating to 6 months may be given to make up for Sundays and other holidays which are practically denied to them. Furlough for 2 years on full pay may be granted instead of on half pay.
 4. As prospects of promotion for civil assistant surgeons do not compare favourably with those of the members of other provincial sister services, it is suggested that the prospects of all provincial services be equalized and those for civil assistant surgeons be widened.
 5. At present no facilities exist for the best students of the medical colleges in India to complete their medical education abroad; scholarships tenable in Europe may, therefore be granted to enable them to complete their medical education.
 6. The position, privileges and social status of civil assistant surgeons is considered not to be on the same level as that of other gazetted officers of equivalent rank in the sister services because of their receiving less emoluments. This may be altered.
 7. The number of civil surgeonships held by civil assistant surgeons is at present only 2 out of 22 districts in Central Provinces and Berar. These should be increased to at least about 6 or about 25 per cent. of total. The promotion into the civil medical service may be made by selection according to merit from amongst civil assistant surgeons having service over 10 years. Also civil assistant surgeons possessing the requisite qualification may be made eligible for appearing at the competitive examination for direct recruitment of civil medical service officers as proposed in scheme D, age limit if necessary being relaxed in their cases. Civil assistant surgeons thus promoted should not always be relegated to minor and less popular districts as they have to do the same work and bear the same responsibilities as other officers.
 8. At present the opportunities for operative work at district hospitals are restricted. More facilities should be given. In this connection the practice of mentioning the number of selected operations by individual officers in the annual report should be abolished and only the number performed at certain hospitals should be mentioned, without giving any individual officer's name.
 9. At present no facilities are given to civil assistant surgeons for special training at Research Institutes as are given to military assistant surgeons. Such facilities may, therefore, be given to this class also.
 10. The title of civil assistant surgeons prefixed to their names in official correspondence should be done away with, holding as they do a degree from their universities equivalent to the degree of a British university and possessing a medical qualification which is registrable in the United Kingdom.

The styling of this service as "Subordinate Medical Service" should be discontinued as it is done now in the case of military

assistant surgeons. This way of styling them has been found to lower them in public estimation. The service may be termed as "Provincial Medical Service" instead.

11. Exemption from certain provisions of the Arms Act be granted to civil assistant surgeons in this province as is done in other provinces.
5. I do not think it, at present, attracts the best men or men of that class which it might attract in altered circumstances but if the disabilities referred to above are removed and if prospects and position are improved there is no doubt that men of the requisite stamp would be forthcoming.
6. The following are the sources from which recruitment is at present made:—
 1. Medical graduates of Indian universities and sometimes of English universities.
 2. Recently some posts are thrown open to the senior civil sub-assistant surgeons. These possess no university qualifications nor the preliminary educational standard for such qualification.
 3. Some of the posts are filled by military assistant surgeons forming the war reserve.

Proposed methods of recruitment.

1. The first method should continue the chief source of recruitment as before.
2. As regards the second method, it is, in my opinion, not desirable that men having no medical qualifications registrable in the United Kingdom nor preliminary educational standard for obtaining such qualification should form a source of recruitment to this service. It is therefore suggested that they should not be incorporated into the cadre of civil assistant surgeons. If they have to be promoted because of their meritorious services they should be made honorary assistant surgeons and put into a class by themselves having of course all the privileges of pay and allowances of the civil assistant surgeons.
3. As regards the third method of recruitment I may be allowed to suggest that only those military assistant surgeons who have got diplomas registrable in the United Kingdom should be admitted for such recruitment. This will reduce the war reserve which is most necessary. In order to make up for the large war reserve which is necessary in time of peace as well as to meet adequately the exigencies of military service, I would suggest, 1st that the standard of military assistant surgeons should be raised being made equal to that of civil assistant surgeons, 2nd, the military class should be thrown open to Indians who may elect to have a military career possessing the requisite preliminary educational standard to obtain the university qualification registrable in the United Kingdom. This will probably mean increase in the cadre of the military assistant surgeons in each province and increase in expenditure consequent upon their training to Government. But this extra expenditure will be more than compensated by the large war reserve that will be available and also by the fact that men of right stamp (men belonging to military race) would be entering military department voluntarily, being attracted by the financial help given by Government for their training. This will also remove the necessity of forcing unwilling men to accept military liability for military services for which most of the men at present in the service have no taste. It will also remove the discontent and heart-burning which exists amongst civil assistant surgeons on account of preferential treatment to the military assistant surgeons in spite of their inferior qualifications. Military assistant surgeons will have no ground for complaints as they will be given equal chances of promotion to the civil medical service appointments by the open competitive examination.

18 March 1919.]

Civil Assistant Surgeon W. V. KANE.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

7. If the qualifications of the military assistant surgeons remain the same as at present the throwing open of civil appointments to a larger number would not be at all popular and would not satisfy the civil Indian population. It will affect materially the civil assistant surgeons' service as many of the best civil appointments which are naturally looked upon by them as their close preserve will then be filled up by the military assistant surgeons with inferior qualifications. If, however, the standard of education of military assistant surgeons is raised and he is made to possess a qualification registrable in the United Kingdom there will be no objection to his being given the same chances in civil employment as a civil assistant surgeon.

8. In my opinion all civil assistant surgeons should have compulsory military training during the early part of their service. After this training they should form a war reserve on a voluntary basis and those that volunteer for war service should get temporary commissions as was done in the recent war. If the liability to military service of all grades of civil assistant surgeons is made voluntary and not compulsory the recruitment is not likely to be affected.

Special questions.

1. My experience in this connection is limited but there is no doubt that in some cases at least such demands are to a certain extent based on racial predilection. I have known of cases where such demands were made, and these could only be explained on the basis of racial predilection because the comparative merits of the doctors had everything in favour of the Indian. But such cases are very few. In the great majority of cases such demands are based on the comparative professional merits of different doctors.

Mr. W. V. KANE, called and examined.

(Mr. Hignell.) He had studied schemes C and D and was in favour of scheme D, subject to the modification that suitable arrangements should be made to safeguard the interests of civil assistant surgeons in both the civil and military medical services. There was no provision in the scheme as it stood at present for the incorporation of civil assistant surgeons in the civil medical service. He would like to see some provision made to secure their inclusion to the extent of 10 per cent. A similar percentage should also be laid down in the case of the military medical service.

Appointments should be made on the result of a competitive examination held in India.

It would be necessary to impose obligations for military service on all private practitioners in order to secure a war reserve. To start with there should be compulsory military training for all, though later on there might be voluntary recruitment.

(General Hendley.) He wanted to do away with the designation of "Civil Assistant Surgeon," as this designation was generally supposed to lower them in the estimation of the public. It did not assist them at all in private practice after retirement. He would therefore do away with this title, and would prefer that an assistant surgeon should simply be styled as "Mr."

If the military assistant surgeons had a five years' course, and were given a complete medical education, he agreed that no difference should be made between them and the civil assistant surgeons.

(Major Cramer-Roberts.) Civil assistant surgeons would be prepared to do military service for a certain period before joining the civil service. A period of three years' military employ before going to civil should be sufficient. They should be prepared to go

2. This question is best answered by the recipients of the medical treatment; so far as I know, however, they seem to have been satisfied. I have heard of no complaints against Indian substitutes.

Questions regarding the Medical Store Department.

1. The sources for stocks of drugs and instruments for annual indent are varied and not fixed ones. Under orders of the Inspector-General, Civil Hospitals, certain drugs have to be obtained from certain firms in India. The others are obtained either in India or from England but the name of the firm from which they are to be obtained has first to be sanctioned by the same controlling authority. Instruments are generally obtained from England. Special instruments from special makers according to the choice of the indenting officer and after getting sanction of the Inspector-General, Civil Hospitals. Drugs on emergent indents are generally obtained in India from different firms.

2. The responsibility for indenting rests with the medical officer in charge of the dispensary or hospital under the supervision of the civil surgeon. It may be a little convenient if the Government Medical Store Depots were made the sole source of supply but, I am afraid, it will not be satisfactory. Certain drugs and instruments are a speciality with certain firms and the indenting officer should have his own choice in selecting the firm. Government Medical Store Depots will not be able to meet the varied demands of different indenting officers. Besides giving discount on purchases over a certain amount, firms allow deduction for breakages and unsatisfactory articles. As they have to secure the good will of the customers they will leave no ground for complaints.

3. I have no suggestions to make as my experience with the working of the Medical Store Depot has been very little.

for military training occasionally. Many civil assistant surgeons would come forward for this purpose if they received sufficient inducements.

(Colonel Banatvala.) He had suggested in his written statement that grade examinations should be abolished, and a post-graduate course of say three months in every five years should be introduced. He admitted, however, that there were certain persons who would not keep their knowledge up-to-date, and that it would be difficult to judge who should be promoted. In view of this he withdrew the recommendation as regards the abolition of grade examinations, but laid stress on the necessity of a post-graduate course.

With reference to the remark contained in his written statement, that the position, privileges and social status of civil assistant surgeons were not considered to be on the same level as those of other gazetted officers of equivalent rank, he explained the inequalities under which they suffered. This was apparent, for instance, in the case of the houses allotted to them as resident medical officers. The accommodation in those houses was based on the rental value which was in turn based on the average emoluments of the occupant. The emoluments of assistant surgeons being lower than those of extra assistant commissioners or judicial subordinate judges, they were provided with inferior accommodation. Another disability was in respect of invitations to durbars in the Central Provinces. All assistant surgeons were not invited to durbars, the privilege being confined to men of the first grade.

He had suggested in his written statement that the number of civil assistant surgeons promoted to be civil surgeons should be raised from 2 out of 22, as at present, to at least 6, or about 25 per cent. of the

18 March 1919.]

Civil Assistant Surgeon W. V. KANE.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

total. They should get this increase at the expense of military assistant surgeons, who were not properly qualified, but still got six out of eight appointments reserved for assistant surgeons.

If, however, military assistant surgeons were given a complete medical education and were fully qualified, he would not insist on this recommendation; provided

that the military classes were opened to all Indians. There would then be no complaint, as the chances of both would be equalized.

(General Hehir.) If Indians were admitted to the military assistant surgeon class they should be employed in station hospitals for Indian troops, and not in British station hospitals.

19 March 1919.]

Major C. F. MARR.

*(The schemes and questions referred to by witnesses are contained in Volume III.)***At Bombay, Wednesday, 19th March 1919.**

PRESENT :

S. R. HIGNELL, Esq., C.I.E., I.C.S. (*Presiding.*)

MAJOR-GENERAL G. CREE, C.B., C.M.G., A.M.S.
 MAJOR-GENERAL P. HEHIR, C.B., C.M.G., C.I.E.,
 I.M.S.
 MAJOR-GENERAL H. HENDLEY, K.H.S., I.M.S.

THE HON'BLE MAJOR-GENERAL G. G. GIFFARD,
 C.S.I., I.M.S.
 LIEUTENANT-COLONEL A. SHAIRP, C.M.G., Indian
 Army.

and, as co-opted members SIR T. NARIMAN, Kt., the HON'BLE COLONEL H. E. BANATVALA, C.S.I., I.M.S., and
 LIEUTENANT-COLONEL H. ROSS, O.B.E., I.M.S.

MAJOR A. A. McNEIGHT, I.M.S. (*Secretary.*)

MAJOR C. F. MARR, I.M.S., Medical Storekeeper to Government, Bombay, called and examined.

(*Mr. Hignell.*) The Bombay Medical Store Depot was situated in a central place between the two Railways, Bombay, Baroda and Central India and Great Indian Peninsula, and was as well placed there as anywhere else in Bombay. The surroundings were bad but he hoped that the Bombay Improvement Scheme would improve the site considerably. He was not in favour of removing the medical stores depot to a place outside the city of Bombay. The depot had to cater for hospitals in Bombay and also had to make a great deal of local purchases. If the depot was removed from the business centre, there would be a great dislocation of work, as it would not be possible then, as at present, to have personal interviews with tradesmen and contractors in Bombay. Work could not be carried on so efficiently if the depot were outside Bombay. The actual accommodation in the depot was extremely insufficient, but this would be remedied by the erection of buildings now in progress. Bombay is the port of embarkation and disembarkation both in time of war and in peace. The depot also serves the Admiralty, and it should therefore be as near the docks as possible.

The total strength of his staff was roughly 250. Four members of his superior staff who belonged to the Indian medical department were comfortably housed, but that was arranged by the Military Works. The others had to make their own arrangements but he would greatly prefer that they should be accommodated on the depot premises.

The depot staff was insufficient owing to the present unsatisfactory accommodation. It might, however, be possible even to reduce the present staff when the depot was housed satisfactorily. He had, at different times, made representations to higher authorities for an increase in his staff. His requests had always been granted.

The numbers of highly trained men, such as clerks, etc., on his staff were insufficient. If any of these men fell sick, it was very difficult for him to arrange for the work to be done during their illness. He required understudies to take the place of such men during their absence.

The quality of the staff was also poor. It was not possible to get really good men for the pay that he could offer. Their pay ought to be improved, and without better pay it would be impossible to recruit efficient clerks.

The Director-General, Indian Medical Service, had hitherto sanctioned only some detached schemes which he had submitted for improving the pay of the clerks, etc. He had lately submitted a scheme for the reorganisation of the whole staff in which he had requested sanction to what he considered the minimum wages on which satisfactory men would be obtained

in Bombay. He understood that his proposals were now being considered.

The compounders on his staff did not possess sufficient technical knowledge. Their pay was only Rs. 20—25 a month. The case of the compounders had been included in the reorganization scheme which he had submitted to the Director-General, Indian Medical Service.

Some of the compounders had no previous training. They were trained in the depot. In Bombay there was a Government standard examination for compounders but it would be difficult to get passed men for Rs. 20—25. They could be got for Rs. 30—50. He recruited his staff himself. He agreed that the present method of employing insufficiently trained compounders constituted a serious danger.

He was not satisfied with the present system of accounting. The accounts office was far away from Bombay. It would be better if the accounts office was nearer and easily approachable. He would not have a branch of the accounts office in the depot. He feared that it would lead to collusion between the accounts clerks and his own. The danger of this was so great that it more than counterbalanced the advantages which would result from a close connection between the accounts office and the depot.

Stock-taking was of two kinds, one running and the other annual. The annual stock-taking was going on at present and it generally lasted a month.

The depot was not closed during the time of annual stock-taking. Their programme was so arranged that there would ordinarily be no demands on them at the time of the annual stock-taking. The depot was, however, open to all urgent work.

Private firms did not close their shops during their annual stock-taking. The reason for this was that, for some time previous to stock-taking, all articles which it was not desired to carry over into the following year (those which had deteriorated or were out of date, etc.), were put on one side. When stock-taking commenced everything that was in good condition was removed from the shop, and practically nothing but the articles above mentioned which had been previously set aside was sold.

In his depot, instruments, etc., which had deteriorated but were repairable were repaired and taken into stock again. Surgical instruments beyond repair were destroyed and unserviceable appliances, etc., sold. Drugs which had deteriorated or began to deteriorate were destroyed. Such drugs were never sold.

As storekeeper, he had nothing to do with the equipment list and was not in a position to say whether it was up to date. His opinion was that it was not up to date. He thought that the preparation

19 March 1919.]

Major C. F. MARR.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

of the equipment list ought to be taken out of the hands of the Director-General, Indian Medical Service, and entrusted for revision to a board or a series of committees consisting of physicians and surgeons from civil hospitals and military medical and veterinary officers with practical experience of field service; the latter would advise with reference to field equipment, due care being taken to eliminate the demands of some faddists, i.e., the depot equipment list should be practical and up to date and revised annually.

He said that field medical equipment was maintained in the depot in sufficient quantities ready for issue at short notice.

The depot supplied only Government institutions, and such other institutions, as were recommended by the civil administrative medical officer. It did not enter into competition with ordinary druggists or chemists, but supplies many articles to the above mentioned institutions at prices lower than those prevailing in the open market.

There were three different price lists for the different categories of institutions supplied, namely (a) Military hospitals, (b) Government civil hospitals and dispensaries and charitable institutions, and (c) non-Government and private bodies.

He recommended that the manufacture by Government of drugs, etc., should be extended, but only with the object of meeting Government requirements, and of utilising indigenous raw materials as far as possible.

The idea that Government should attempt to pioneer new drug industries was a splendid one, but he thought that there were practical difficulties in the way. At present the public was not protected by any legislation. The Government of India had passed no laws prohibiting trading in adulterated drugs. He would strongly deprecate the encouragement of such industries by Government, until an efficient adulteration of drugs' act was passed in this country. He considered that in the absence of such legislation the Indian market would become still more flooded with impure drugs than it is at present involving serious danger to the purchasing public.

He was in favour of making India as self-supporting as possible. A great deal of raw materials were not at present available in India but they could be made to grow under the guidance of experts. He would not entrust the task of cultivating medicinal plants to men who had only a superficial knowledge of it. The experiment should be tried only under the guidance of real experts.

He had no objection to necessary additional and urgent indents but he felt sure that if medical officers were more careful in the preparation of their indents, 90 per cent. of such indents would disappear. Although this was a closed month, he had received 86 ordinary supplementary, and about 200 urgent indents since the first of March, and this caused a great deal of dislocation in the work of stock-taking.

(General Hehir.) A training in a medical stores depot was not necessary to make out an indent as the rules on the subject were so plain that there was no chance of any misunderstanding except by the willfully careless.

(General Giffard.) He did not think it advisable to do away with the countersignature of the indents by Surgeon-General or Inspector-General of Civil Hospitals. Hitherto it had served as an important check. If the Surgeon-General or the Inspector-General of Civil Hospitals could not countersign the indents, at least his Personal Assistant, if a medical officer, should sign them for him. If civil surgeons were allowed to indent on the stores directly, the position would go from bad to worse.

He would be glad if A. R. I., volume II, paragraph 178, were amended so as to absolve storekeepers from all responsibility for seeing that indents have been correctly prepared as regards scale and quantity.

He thought that all medical indents should be checked by medical men and that therefore indents submitted by municipal chairman, etc., should bear the signature of their medical officers. He never refused to comply with telegraphic indents and he had not held up supplies even in cases where indents were not signed by medical men.

He did not think that there was any delay on the part of the stores in the matter of supply to indenting officers. If the indent was an ordinary one, it had to take its own turn. Only the urgent indents could be given preference over ordinary indents. He was sure that there was no red-tapism at all. The complaints referred to in the question about delays did not apply to the Bombay depot or so far as he knew to any other depot. Delay might be caused by either late submission of the indents or their careless and improper preparation.

(General Hehir.) He was not in favour of having small subsidiary distribution depots. In his opinion there was no necessity for them.

(General Giffard.) He did not see how improvements could be made in the present method of indenting from Europe for medical stores except by quickening up the whole machinery. The present great difficulty was the distance between India and Europe whence the supplies had to come.

If the storekeeper was to meet effectively all the urgent demands made on him for things that could be purchased locally, he should be given larger financial powers in regard to local purchase. He should be allowed to purchase any article up to the value of Rs. 500, without any restriction as to the number of such purchases that might be made during the year.

If a drugs' act was introduced in India, the probable result would be that many reputable European firms would bring out their agencies and stock large godowns in India. They would probably also start their own factories. At present they would not do so because of the absence of any such legislation. If such firms brought out their agencies to India, then the medical stores depots need not stock so much as they do at present, so that they could be greatly reduced in size, or possibly abolished in their present form in which case those private firms would probably supply civil institutions, etc., direct, as is done in England. On the other hand under such an arrangement drugs might cost Government more than they do now. It was impossible to estimate even approximately what the financial effect of this would be.

In his opinion it would be practically impossible to separate the stores department from the manufacturing Department of a medical stores depot as they were so dependent one on the other.

(General Hehir.) The medical storekeeper should store everything possible and not confine himself to stocking non-deteriorating articles.

He had got a chemist on his staff purely as a war measure. He would prefer to have a permanent chemist on the staff and a man of even higher qualifications. The Madras and Bombay depots should each have a chemist on its staff for ordinary routine manufacturing and analytical work, and in addition a highly qualified chemical analyst to carry out research work.

The medical storekeeper should have a sufficient knowledge of business methods and the manufacture of drugs on commercial lines. He did not consider it advisable that a lay business man or commercial chemist should be placed in charge of these depots.

He did not consider that medical store depots could be run on business lines as their methods were so essentially different to those of a business house. The present system of issuing stores was entirely different from the selling of private firms. A private firm did not hold the large stocks held in store depots; it might frequently keep only samples of what it had to sell and issue orders on England on receipt of actual orders from customers. A business firms

19 March 1919.]

Major C. F. MARR.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

object was to have at one time as little capital outlay on actual stock as possible, and to turn that stock over as quickly as possible. A percentage only of a firm's capital was in their actual stock, the rest going into the purchase of more stock.

The store depots had on order stocks in accordance with the previous demands estimated on a three years' basis in the case of some items, and one and a half years in others. This entailed an unbusinesslike outlay of capital. Local dealings would lessen this. The depot system was an extravagant credit system.

The depots took back second-hand serviceable stores and gave credit for them. This again was bad business.

The accountant of a mercantile firm was on the premises, whereas the accountant who dealt with the Bombay Medical Store Depot was in Calcutta—a thousand miles distant. It was impossible for the depot to be run on the lines of a business firm; but at the same time the depot should do its best to utilise the money placed at its disposal to the very best advantage possible, that is, by good book-keeping and accounting. They should reduce their stock in hand to the lowest safe amount possible. This could only be attained by quick and accurate dealings with the accounts officers and suppliers. His previous suggestions with regard to the introduction of a drugs' act, the establishment of responsible European firms in India with a possible abolition of medical store depots would enable this to be done in so far as

quick and accurate dealings with the suppliers were concerned. The increased efficiency of the accounting must be left in the hands of the Controller of Military Supply Accounts and the Finance Department. The European firms referred to above would charge C. I. F. prices and profits. But he did not think that these prices would compare unfavourably with those which Government charged at present, on account of the healthy competition which would arise and undoubtedly cause them to cut their prices as low as possible.

The prices of a business firm were plainly stated to the purchaser and were calculated on purely business lines, whereas it was doubtful if this was the case in the prices of medical store depots. The percentages which the Controller added for charges other than military appeared to the witness to be arrived at in a rough and ready fashion. He would be glad if the Controller could explain the method by which he arrived at these percentages, and support his explanation by actual figures. What he meant was that a business firm calculated these figures from its actual balance-sheet and profit and loss account, and allowed for a certain margin of profit. If the Controller did not do this, it was necessary to know the method which he employed. He contended that Government should not charge interest on its capital outlay, since by doing so it was directly charging the public interest on its money which had been extracted from it in the form of taxation, etc.

DR. W. W. NUNAN, M.D., Honorary Temporary Captain, Indian Medical Service, Bombay.

Written statement.

Questions for witnesses.

1. R. A. M. C. officers not given the work for which they are most fitted (especially in the case of temporary officers); officers comparatively inexperienced in tropical diseases.

I. M. S.—Inadequate pay. Insufficient leave. Friction between services.

Remedy.—Abolition of the system which includes two services Royal Army Medical Corps and Indian Medical Service working in India side by side. I am not able to discuss organization of medical services (existing or suggested) except on general lines.

An Indian Medical Service, increased in numbers and better paid, with proper facilities for leave and study, should be able to do the work of the Indian army and the British army in India, as well as supply the medical needs of civilians and form a reserve for war.

7. Medical service reserve for war previously trained in military work essential.

8. I gather that it has proved very valuable.

10. Study leave at stated intervals essential but more for special subjects.

11. Department for research essential.

12. The rise of independent medical profession Indian and European has diminished private practice of Indian Medical Service officers. Curtailment of fees has had a similar effect.

The opposition by European independent practitioners will not increase to any great extent.

Reasons.—Cost of living, separation from families, complete loss of income in illness or absence on leave, lack of pension, etc.

Special questions.

1. Racial predilection a very strong factor especially in the case of women and children.

Apart from comparative professional merit, the European medical man is more likely to give his advice for what it is worth, and to insist on his orders being carried out.

Again, one will hear it occasionally said that the indigenous practitioner should know more of the diseases of the tropics than the European, and this opinion may be acted upon.

DR. NUNAN, called and examined.

(Mr. Hignell.) He had been practising in Bombay for practically 8 years. His private practice was incomparably better than it had been when he came out. His practice had been almost confined to Europeans. The recent war raised his private practice in Bombay owing to the shortage of Indian Medical Service officers. His principal grievance was that he did not have access to any hospital practice. If his patient was very ill and had to be removed to a hospital he could no longer attend him. He had not been allowed to visit public hospitals professionally. He had been on the staff of a nursing home which was attached to St. George's Hospital since 1914, but in practice it was useless to him for the following reasons: there were only two beds in the St. George's Nursing home, and these beds were open to the other members

of the staff which included practically all the Indian Medical Service officers and all the private practitioners in Bombay, as well as the railway doctor and the police surgeon. Consequently it was nearly always impossible to find a vacancy. If there was a vacancy, the average European found it too expensive, as he was charged Rs. 15 a day for the room alone, everything else being extra, even medicine. As the average European cannot afford such expenses he generally went into the private wards of the hospital or into the general wards, with the result that the patient passed out of his hands.

He could never go on leave or take a holiday. If he did so he had to leave his practice behind him and pick it up when he returned. He could not get a *locum tenens* to take his place. If he proceeded on

19 March 1919.]

Dr. W. W. NUNAN.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

leave he gave his patients the names of two or three doctors and left it to them to select a man.

At the present time he was practically the only European private practitioner in Bombay. He did not think that European private practitioners would object to forming a war reserve. Personally, he had been passed unfit for any kind of military duty.

(General Hendley.) In England there were many nursing homes where one could send one's patients to, and still continue treating them. If there were nursing homes in Bombay his grievance would disappear.

As he was the only European private practitioner in Bombay he did not think a war reserve could well be formed there.

The number of European private practitioners in Bombay would not increase as there were far too many difficulties to contend with.

(General Hehir.) He was a member of the Indian Defence Force and, being a doctor, he was automatically appointed as the local medical officer of the force.

He considered that the private practice of Indian Medical Service officers had markedly declined in Bombay owing to the increase of Indian private practitioners.

He was not prepared to say whether the duties connected with the superior appointments in civil could be as efficiently performed by the independent medical profession in India as by Indian Medical Service officers. He was also not prepared to answer the question whether professorial chairs could be efficiently filled by the Indian medical profession.

(General Giffard.) Private practitioners would gladly welcome any proposal under which they were allowed practice in hospitals. Personally, he was

quite willing to serve in a hospital in an honorary capacity. He was of opinion that they would also take up professorial appointments in the same way if they were qualified for such posts.

Government could not dispense with the services of Government servants for professorial and hospital appointments. If an Indian Medical Service officer who held an important appointment proceeded on leave he could be immediately replaced by another Indian Medical Service officer who would be equally highly trained. This course could not be adopted in the case of private practitioners as they would have no reserve to fall back upon.

He did not think it was fair to the private practitioner that Government should treat for fees and provide rooms in State hospitals for people with moderate means. This difficulty might be overcome by private practitioners being allowed to have access to hospitals and by allowing them to treat their patients in paying wards.

Government should continue to provide hospital accommodation for the public, and patients should be charged according to their means.

If Government only treated those who were entitled to its services, and the poor, and left out the general public, there would be a general outcry.

If Government closed down its private paying wards in general hospitals there would be very few, if any, private practitioners who would be willing to sink the capital required to provide nursing homes.

(General Hehir.) The financial prospects of the Indian Medical Service were certainly not encouraging. Personally, he was glad he did not belong to the service.

DR. SORAB K. NARIMAN, M.D., B.SC., ETC., Bombay.

*Written statement.**Questions for witnesses.*

1. The medical services now existing in India were established some 50 or more years ago, when medical education on the western lines was in its infancy. Times have rapidly changed; the medical education has not only made immense progress, but in later years has improved so considerably that the average medical graduates of the Indian universities are able to obtain medical qualifications in Great Britain with ease. Several Indian medical graduates now possess the highest medical qualifications obtainable in England, such as M.D. (London), F.R.C.S. (England), M.R.C.P. (London). In the city of Bombay at present several hospitals both general and special are solely conducted by Indian medical men and women, some of whom are wholly educated in India, while others after getting their medical degrees in India have supplemented their education by further study in England. The splendid work done at these hospitals compares very favourably with the work done at the Government hospitals in Bombay. The war has added another proof of the great efficiency of the medical graduates of the Indian universities, some 700 of whom got temporary commissions in the Indian Medical Service, many more performed the civil duties in place of Indian Medical Service men withdrawn, and again others worked in an honorary capacity in the war hospitals in Bombay. Taking all these facts into consideration, radical changes in the medical services are now necessary, such as would conduce to increased efficiency and to the betterment of the Indian medical profession. It must be admitted that the services should be so reorganised as to meet in a fair way the legitimate demands of the Indian medical men without putting a very heavy financial burden on India.

I do not approve of any of the four schemes for the reorganisation of the medical services referred for my opinion as they fall short of the views expressed by me above. I am not in a position to speak of the

advantages or disadvantages of the unification of the British and Indian army medical officers in India. I, however, hold that no British army officer should be incorporated in any of the Indian Medical Services in the way suggested. Under the circumstances I have no other alternative but to suggest a scheme of my own as indicated in the appendix hereto. I may state at the outset that I am not competent to express any opinion on the defects of the Royal Army Medical Corps and the Indian Medical Service in India.

The principal features of my scheme are:—

- (a) That it affords a larger military career and a smaller civil career to the officers of the Indian Medical Service. Although this service is primarily a military one, only 38 per cent. of its members are employed on military duties and 62 per cent. on civil duties (*vide* Report of the Royal Commission of the Public Services in India, page 244). I want to reverse this proportion, giving 450 for military and 250 for civil purposes.
- (b) That it abolishes the class of officers known as military assistant surgeons whose preliminary arts training and medical education are much inferior to those of the medical graduates of the Indian universities, whose military work can be performed by warrant officers and trained men in the British army, and whose employment as house surgeons at the Jamsetjee Jejeebhoy Hospital, Bombay, has been detrimental to the interests of medical education.
- (c) That it affords a great field for the development of Indian medical talent by throwing open almost all posts now reserved for the Indian Medical Service, since out of about 475 such posts, 250 are to be filled by officers

19 March 1919.]

Dr. SORAB K. NARIMAN.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

- of that Service and the remainder by officers of the civil medical service.
- (d) That it removes to an extent the disadvantages to Indians by the competitive examination for the Indian Medical Service being held in London, as 15 Indian medical graduates are to be sent to England at Government expense. Other Indian candidates wishing to compete at their own expense are not precluded.
 - (e) That it provides for a better and wider selection of the staff of professors and assistant professors at the medical colleges affiliated to the Indian Universities.
 - (f) That it raises the status of Indian medical graduates by calling them medical officers and by increasing their pay.
 - (g) That it fulfils all the military requirements (3 per mille) for a permanent Indian Army of 150,000, forms a considerable reserve for a reserve Indian army of 300,000, and satisfies all the civil requirements of the country.

2. My scheme will fully meet the needs of the permanent Indian army, and also the needs of a supplemental army of 300,000 Indian troops to a certain extent. If small retaining fees be given to medical practitioners in the different towns on the condition of their doing the civil work in time of war, a sufficient number of officers of both the services proposed by me will be available for work for the whole supplemental army.

I have hopes that the War Office will approve my scheme, in which efficiency is combined with due economy.

3. The scheme I propose will, I am sure, meet the views of the medical profession in India and attract good recruits. As for the professional opinion in England, I am afraid, with the home sickness caused by the war, my scheme will not satisfy the demands of the English medical men for some years. In case a sufficient number of British recruits be not obtained, I recommend that temporary service (say for 3 or 5 years) be offered on good remuneration, as was done in the time of plague. Then several batches of medical men (myself included) were sent out to India.

4. When British medical officers were withdrawn from the charge of Indian troops, civil districts and jails, the work was carried on smoothly and efficiently by the Indian medical graduates. I have not heard of any complaints of inefficiency.

5. The scheme will fully meet the needs of the civil administration in India. In case of war it will be affected but little, if the supplementary army does not exceed 300,000.

6. Yes, it gives sufficient and efficient reserve for war.

7. There is no further necessity of a medical service reserve.

8. The Indian Medical Service reserve (civil side) was of great value during the war, but many officers could not be relieved on the ground that they were indispensable for civil work and almost all were out of touch with the military for years, being thus no better than new recruits.

9. I have explained in my scheme.

10. Yes, the special leave for study is absolutely necessary. The period of leave will depend on the specific study, but at least one year's leave to England on two occasions must be given.

11. I think a special department of research is absolutely necessary under the direction of highly paid experts from the whole British Empire specially selected and engaged for the purpose, under whom capable officers of the Indian Medical Service and the civil medical service should work and carry on the research. These expert directors must be independent of any departmental control. No private practice should be allowed to them.

12. The private practice of officers of the Indian Medical Service has not declined in the city of Bombay; on the contrary it has increased. I am sorry, however, that the real prestige of this fine old service is waning in the eyes of the local medical profession.

APPENDIX.

PROPOSED SCHEME FOR THE REORGANIZATION OF THE MEDICAL SERVICES IN INDIA.

The scheme consists of two services:—

- (1) The Indian Medical Service for the whole of India, mainly military and only partly civil. The officers are to be styled as at present by their military ranks.
- (2) The Indian civil medical service for the whole of India, mainly civil and only partly military. The officers are to be styled as medical officers in three grades.

1. Indian Medical Service.

The entrance into the service is by a competitive examination to be held in London, twice a year, and open to all British and Indian subjects possessing the qualifications now required. The Indian candidates must produce a certificate that they have attended the clinical practice of a large London or provincial hospital for nine months, *i.e.*, three months in medicine, three months in surgery, and three months in obstetrics. The number of selected candidates must, as far as possible, be 50 per cent. British and 50 per cent. Indian, so that in about 20 years' time the service will contain an equal number of British and Indian officers.

The strength of the service is to be the same as at present; 450 are to be employed on military duties with the permanent Indian army of 150,000, 250 on civil work, while the remainder will form a reserve for leave purposes, specially study leave. Only about 25 high administrative posts are to be reserved exclusively for this service. All the other posts now reserved are to be thrown open, as permanent vacancies occur, to that service and the Indian civil medical service in equal proportions. The posts of professors in the colleges are separately dealt with below. The only anomaly will be that for performing the duties of identical posts, the officers of the Indian Medical Service will get much higher pay than the officers of the civil medical service. Some such arrangement, however, exists at present in the Educational service. There should be examinations for promotion to the rank of captain, and also to that of major. All officers in civil employ must undergo military training at intervals of every five years. Study leave on full pay should be given at least on two occasions. The acting posts in the military as well as civil side should be filled either by the officers of the Indian Medical Service or by officers of the civil medical service.

Private practice of visit-consultant nature should be allowed, as long as it does not interfere with the official duties of the officers. The officers should not be allowed to keep consultation rooms, nursing homes, or private hospitals, and they should not be allowed to work for insurance and other companies on fixed remuneration or job work.

To compensate to a certain extent for the disadvantage to the Indian candidates by the competitive examination being held in London, I recommend that the Government of India should send to England every year 15 medical graduates selected by the Indian universities from among their own graduates, to compete for the service, and the Government should defray the expenses of their passage and of two years' residence in England at £400 a year. This concession should not preclude other Indian candidates from appearing at the examination.

19 March 1919.]

Dr. SORAB K. NARIMAN.

[Continued.]

*(The schemes and questions referred to by witnesses are contained in Volume III.)**Indian civil medical service.*

The entrance into this service should be by a competitive examination to be held at Delhi, twice a year, and open to all British and Indian medical men who possess qualifications recognised by the General Medical Council of England and registered under one of the Indian Medical Registration Acts. The successful candidates must undergo a military training and a course of military medical subjects for at least six months. Within the first three years of service they must be posted to some resident appointment in a large military or civil hospital for at least six months.

All officers of this service should be liable to perform military duties when required to fill temporary vacancies in time of peace and to go on field service in time of war. Military training with Indian troops must be compulsory at an interval of every five years up to the age of 45. When on military service or under military training the officers should be given temporary commissions of lieutenant, captain or major, according to their grade in the service.

The strength of the service for the present I calculate at 1,500 (225 for the civil posts now held by the Indian Medical Service, 940 for the posts now held by civil assistant surgeons and military assistant surgeons, and about 350 for acting appointments in both the Indian Medical and the Indian civil medical Services).

I propose three grades for this service, and promotion to each grade by an examination. The pay should be from Rs. 250 rising to Rs. 750 per month in the ordinary course. I also recommend that 30 officers of over 15 years' service (2 per cent. of the whole strength) selected by the medical board for meritorious service be paid up to Rs. 1,000 per month. Private practice of the same nature as proposed for the Indian Medical Service should be allowed. Study leave on full pay should be granted on two occasions; and

to encourage officers to go to England, study leave may be combined with other leave.

The posts of professors and assistant professors in the medical colleges affiliated to the universities should be open to medical men throughout the British Empire so that the best men can be selected by the Government of India on the recommendation of the medical board. The pay should be on an adequately high scale, and no private practice should be allowed.

In the above scheme the present Indian Medical Service officers will remain in the same new service; the class of officers known as military assistant surgeons will be abolished, the present incumbents being allowed the option of retiring on gratuity or of remaining till ripe for retirement in due course; the civil assistant surgeons may be incorporated in the proposed civil medical service on the same terms as the officers of that service, barring the entrance competitive examination, or they may be permitted to retire on gratuity, or to stay in service till they are eligible for retirement.

As for the military and civil sub-assistant surgeons, I strongly hold that their salaries should be substantially increased. The increased scale proposed in the new budget of the Bombay Government is not adequate to attract good men to this service. I propose the pay should be from Rs. 80 to Rs. 250 according to grades, and further that 2 per cent. of the whole strength, selected by the medical board for meritorious service from men of over 15 years' service, be paid up to Rs. 350. The present bond-system should be discontinued as soon as practicable. I am sure if the service be made more attractive as I suggest, there will be no difficulty in getting suitable recruits.

The medical board referred to in this appendix should be a board consisting of a certain number of members nominated by the Government of India and others elected by the elected members of the various Medical Councils in India.

Dr. SORAB K. NARIMAN, called and examined.

(Mr. Hignell.) The witness did not approve of any of the four schemes, and suggested a scheme of his own proposing two services one of which would be mainly military and partly civil, and the other mainly civil and partly military. Members of the latter should not have military rank except when they were on military duty or were receiving military training. He did not share the view that much importance was attached to members of the civil service holding military rank or wearing uniform.

(Colonel Banatvala.) In corroboration of the statement that the war had furnished another proof of the efficiency of medical graduates of the Indian Universities, he explained that during the war the number of major operations performed in civil hospitals had not fallen off, although the work which used to be done by civil surgeons had been carried on by Indian trained doctors. In making this statement he was referring only to the Bombay Presidency.

If medical practitioners were given small fees they would assist the civil surgeon, and others in their hospital work. They would have to perform civil duty when the actual civil officers were withdrawn for military duty. All the officers in the civil medical service should be kept under training. They would be willing to join military duty when the time came. It may be that civil assistant surgeons did not volunteer freely in Assam, but in Bombay several persons came forward voluntarily. If this were a condition of their service they would surely not lag behind. The suggestion was a practicable one. He did not know the exact number of persons who had volunteered for military duty in the recent war, but was sure that a sufficient number would be forthcoming to form a war reserve. He was most hopeful about getting a sufficient war reserve, though it was pointed out to him

that only 70 out of 700 civil medical practitioners in Bombay had come forward in the late war.

In the civil medical service he provided a reserve of 1,000 for military duty. In time of war they would do military duty, and no civil duty. Under his scheme it would be a condition of their service, to join military duty. He condemned the bond system and did not blame the sub-assistant surgeons who paid the penalty laid down in the bond rather than proceed on military duty. This was no breach of the bond as the conditions in the bond were the obligation either to go on military duty or to pay a penalty of Rs. 400. He was of opinion that the one thousand members of the civil medical reserve would not resign, but would be prepared to go on military duty as they had given their word and would be undergoing military training. Their word would be better than any bond.

The number of Indian Medical Service officers in civil employ who were not available for military duty during the recent war, on the ground that they were indispensable for civil work, was less than one half of the total. Almost all of them had been out of touch with the military for years and were no better than new recruits, as they had received no military training since they went to civil and were out of touch with troops. For instance, professors of colleges who were sent for military duty were in no better position than recruits. If a professor of midwifery were sent out after 25 years' service he would be like a new recruit so far as surgery was concerned. In the military more surgery than medicine was required, and the professor of midwifery would not be of much use in military work.

The real prestige of the Indian Medical Service was waning in the eyes of the local medical profession. This was apparent from the fact that he found that an Indian Medical Service officer took up a case which he had refused. In Bombay there ought to have been a

19 March 1919.]

Dr. SORAB K. NARIMAN.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

large number of private European practitioners but they found it difficult to compete with Indian Medical Service officers on account of the official position of the latter. Their position gave them a great advantage much to the detriment of the independent medical practitioners. They were also taking up work for insurance companies which any private practitioner could do. They were not doing their regular consultant work, but went wherever they were called. If an Indian Medical Service officer gave up service and started private practice he would not have a quarter of the practice he now enjoyed.

(General Hehir.) In the interests of education professors should not be allowed to practise. They should not be recruited only from the Indian Medical Service but recruitment should be made from among medical men all over the British Empire. They might be engaged on short terms if necessary. He was anxious that the best men should be recruited even if they had to be paid a higher remuneration.

(General Giffard.) He did not intend to exclude the Indian Medical Service from the field of selection, his only anxiety being to get the best possible professors.

(Sir T. Nariman.) There should be a large number of British officers in the service. Even if the attractions of private practice and professorial appointments were taken away, British medical officers would be forthcoming eventually, though there might be some difficulty for the first two years.

He was not in favour of simultaneous examinations, and considered that the suggestion in the Reforms report under which a person passing an examination in India might be sent for training to England was not quite practicable in regard to the Indian Medical Service.

Private practitioners would be willing to give up their practice to receive military training provided they were given some retaining fee.

He upheld his opinion that the work of civil hospitals, etc., had been carried on quite efficiently in the absence of Indian Medical Service officers who had been withdrawn for war duty, though his attention was drawn to the evidence of other witnesses to the contrary. The increase of tuberculosis in the jails could not have been due to the fault of medical officers, and might have been due to causes which had not been ascertained.

In suggesting that the competitive examination for the civil medical service should be held at Delhi he was simply actuated by the feeling that Delhi was the capital of India. It could, however, be held at Calcutta, Bombay or any other place.

He did not like the idea of an advisory board to select professors from among Indian Medical Service officers. Selection for such appointments should be made in the open field throughout the British Empire including Indian Medical Service officers.

(General Hehir.) Professors should not be allowed to take up private practice, though it was not prohibited in the United Kingdom, where, however, professors of scientific subjects were unpaid. As they were all honorary they could not be prohibited from doing private practice. In big towns like Calcutta, Bombay and Madras there were many practitioners of the same stamp as the professorial staff, and thus the public would not be losers by being deprived of the clinical experience of professors.

The number of Indians holding the highest medical qualifications obtainable in England was large. Holders of the L. M. S. of the Bombay University were formerly not allowed to go up for the M. D. degree in London, and had to pass a matriculation examination there which was a great stumbling block in their way. Now the Bombay University had so altered their regulations that a Bombay L. M. S. could also go up for the M. D. degree. There had, therefore, been an increase, within the last few years, in the number of persons qualified in England. He could not state the number of doctors with these higher qualifications.

The further recruitment of military assistant surgeons should be stopped, but those who were at present

holding these appointments should be kept on till their retirement. He was sure that it would not be possible to get recruits for this class if their standard of preliminary education were raised, and the course was extended to five years, and they were made to obtain qualifications registrable in England. They were much better off in other lines such as the police and would not care to join the military assistant surgeon class.

In suggesting that 15 Indian graduates should be sent to England at Government expense to compete for the Indian Medical Service he had put in only an approximate figure so as to provide for a certain number being sent from all the provinces, and in the belief that Government would not be prepared to send a larger number.

The examination to be held in India for the civil medical service should be open to British medical men. No doubt there would be very few Britishers competing in this examination, still the door would be open to them if they liked to do so. There might be some, the sons of officials in India, who may like to compete in this examination, and there would be a number of planters' sons who would not like to undergo the expenses of education at Home, and would prefer to compete in the examination held in India.

The Indian civil medical service would be inferior to the Indian Medical Service as regards pay, but their members would be filling a number of posts occupied by the Indian Medical Service. An arrangement of this kind already existed in the education service where a person holding the same post and performing the same duties as a member of the Indian Educational Service got less pay than a member of that service.

As suggested in his written statement there should be an increase in the pay of civil as well as military sub-assistant surgeons. At present their pay was quite inadequate and quite incommensurate with the examinations they had to pass, and the course of four years they had to undergo. He admitted there had been a great increase, considering the pay they drew 80 years ago, and that there had been an increase of pay from time to time, but pointed out that times had changed considerably and the pay which attracted a good man then was quite inadequate now. The bond system should also be abolished as far as practicable.

He would get rid of the stipendiary system as far as possible, and would urge that students who were prepared to pay for their education should be admitted in larger numbers. At present many of them were refused admission.

(General Hendley.) There would be no objection to the admission of women into the medical service on terms of equality with men.

(Colonel Banatvala.) The candidates appearing for the examination for the Indian civil medical service would not necessarily be inferior to those entering the Indian Medical Service. He did not desire that they should be inferior. Their medical education would be almost exactly the same as that of men trained in England, though it must be admitted that practical instruction in the English schools was superior. No doubt better pay in one service would attract a better class of officers, but the mere fact that members of the civil medical service got less pay should not indicate that they were inferior. The fact that members of one would be recruited in India and the others in England justified higher pay in the case of the latter.

It was not his intention to put the civil medical service on a lower plane than the Indian Medical Service. Nor did it necessarily follow that, because the candidates for the one were trained in India and for the other in England, the officers of the civil service would be inferior to those of the Indian Medical Service. The fact that sometimes an Indian student who failed to qualify in India went to England and obtained a qualification there within six months of his arrival there showed that a doctor trained in Europe was not necessarily superior to doctors trained in India.

19 March 1919.]

Dr. SURJU PERSHAD.

(The schemes and questions referred to by witnesses are contained in Volume III.)

Dr. SURJU PERSHAD, RAI BAHADUR, General Secretary, All-India Sub-Assistant Surgeons' Association.

*Written statement.**Questions for military and civil sub-assistant surgeons.*

1. No; I am not satisfied. At present a sub-assistant surgeon is a warrant officer in the Indian Army only for the purpose of discipline and partly for the purpose of dress (para. 283 of A. R., I., vol. II). Nowhere else in A. R., I. the sub-assistant surgeons are mentioned as warrant officers. The sub-assistant surgeon holds a very low official status or none at all in the Indian army and carries no privilege as allowed to the sister service of the military assistant surgeons and other departmental warrant officers, regarding free passages, travelling allowances, leave rules, rewards for the language examination, house rents when provided with the inferior houses or on leave, horse allowance when attached to an Indian cavalry corps, field and separation allowances.

Until we are treated on the same level as others of the same rank in the army (never mind warrant officers) and allowed exactly the same privileges, the rank of warrant officer will remain unsatisfactory.

In Volume X of A. R., I., in the definition of the departmental officers and warrant officers, sub-assistant surgeon is omitted.

Government should think over the question and think over the point, that when an officer's rank is given to the sub-assistant surgeons, all privileges connected with it must be allowed to him without any reserve.

It is now high time that by the nature of the education, a sub-assistant surgeon is now receiving during the four years' course, and other circumstances connected with his social position, he be given the rank of an Indian commissioned officer, with all privileges connected with it. The sub-assistant surgeons' association has in all its conferences pressed this demand with reasons, which should no longer be ignored.

2. Yes; study periods would be important. But until we be given a definite idea of the nature and equipment of the newly proposed military medical college, it would be difficult to say, where they should be taken. If the new college only differs from the existing colleges inasmuch as the military drill and discipline is concerned, better would it be to take the periods there.

3. (a) This is against the conclusion to which the Indian Services Commission arrived.

"It should no longer be the case that the civil departments should be adjuncts of the military service. We also think that steps should be taken to secure that even under the gravest war conditions, the civil cadre should not be unduly depleted and in particular that no dislocation of the educational and scientific work of the country shall take place."—*Extract from Report.*

(b) Indian public opinion has several times declared against this principle.

(c) Military sub-assistant surgeons may like such appointments, and in limited number they may be offered to them with precaution that:—

- (i) Reputation of civil hospitals is not spoiled.
- (ii) Posts of original and scientific work are free from the occupation of these military reserves.
- (iii) Posts of hygiene and public health as contemplated by Government on larger scales may be better filled by these persons.

4. The present matriculation standard is quite decent for admission in the present medical school for civil as well as military medical pupils.

5. In my opinion, such a deposit will not have any good effect on recruiting for military or civil sub-assistant surgeons before their training begins. The fact is, because an intending medical student is in straitened circumstances and has little or nothing to defray the expenses of his training; he finds out a sub-

ordinate and cheaper course to go through. Persons having money to deposit, can as well utilize the same and join the higher course of training.

For the present before a qualified sub-assistant surgeon enters Government service, on the civil side, he signs an agreement, and binds himself to pay Rs. 500 in case he fails to complete five years' service. This is a kind of security deposit with the Government.

Military pupils are still further bound to deposit their diplomas for five years, which are not given to the sub-assistant surgeons and thus their qualifications cancelled in case they fail to put in five years' service.

6. No, the bond now signed has got many drawbacks; if instead, retaining service system is started, many civil sub-assistant surgeon will be in reserve for military duty in case of emergency.

7 and 8. No, firstly the civil sub-assistant surgeons on transfer to military find it difficult to maintain their position for want of rank and sufficient pay. Though the scale of pay in the civil is also unsatisfactory, these can command little amount of private practice.

Remedy, etc., to be discussed.

The remedy for making military service popular and volunteering in that branch in larger scale.

- (i) Sub-assistant surgeons during civil employ should be asked to enlist their names in military service in time of need, with prospects of better standing in army and allowance may be offered to them during their civil employ for such enlistment.
- (ii) This system will equally satisfy needs of civil hospitals.
- (iii) It will not be unpopular in the eyes of public.
- (iv) Recruitment in civil employ will not in the least be affected.
- (v) Military hands will always be ready in times of need as there would be war reserve in this way.
- (vi) Civil service will not be unnecessarily depleted, as it may be arranged that a limited percentage of civil hands must be present. Volunteers for military service may be sent for compulsory training and for work in military service before they are actually appointed for the military post.

9. In this connection, I shall have to suggest and put before you my proposals regarding ordinary pension, wound and injury pension and family pension.

(i) *Ordinary pension.*—Length of service required for a sub-assistant surgeon to qualify for a pension is 30 years for the present, which compares very unfavourably with all other ranks of military service. An ordinary sepoy earns his pension after 15 years' service and an enhanced rate after 18 years. Officers can get after 20 years and an enhanced rate after 24 years. Considering the duties of sub-assistant surgeons and want of holidays and Sundays this 30 years period may be made to at least 25 years.

(ii) *Wound and injury pension.*—This should also require improvement. Half of grade pay at least after 20 years' service, one-third after 15 years' service, one-fourth after 5 to 15 years' service. Gratuity if below 5 years' service should be granted when illness has been caused on account of duty and with no mistake of a sub-assistant surgeon.

(iii) *Family pension.*—Present scale of pension for most of the ranks of army combatants and non-combatants gives half of their rank pay if killed in action. Sub-assistant surgeons should not be the only exception to this rule as he gets from one-eighth to one-fourth at present. A follower on Rs. 50 gets Rs. 20 to Rs. 25 as his pension, but sub-assistant surgeon gets less than

19 March 1919.]

Dr. SURJU PERSHAD.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

Rs. 15 which is much below the requirements of his family according to the social status. Educational facilities to children should be equally extended as are offered to other officers.

10. Yes, as Postal Life Insurance is not opened to him Government can go to the extent of making it compulsory to all employés. Government can also help the Family Pension Fund by their grants, but the amount should not lapse for want of heir, but should go to the next of kin.

11. There are many disabilities, foremost amongst which are:—

- (i) *Educational*.—Their qualification should be at least registrable under the British Medical Act.
- (ii) Subordinate service should be merged into the provincial one.
- (iii) Designation of sub-assistant surgeon which has no meaning in military should be abolished.
- (iv) Work should be professional and not of mere clerk, which is not only discouraging to the class but also costly to State.
- (v) Low pay and low rank.
- (vi) Travelling allowance according to E Form.
- (vii) Low percentage of appointments in the higher grade.
- (viii) Field allowance Rs. 5 for all grades which is the result of recent increase is insufficient. 50 per cent. of pay are allowed to civilian establishments of Indian army departments which may be extended to sub-assistant surgeons in absence of the separation allowance.

- (ix) Out-fit allowance of Rs. 300 at the beginning. Rs. 50 per annum for clothing allowance.
- (x) Housing accommodation.

12. There should be one provincial service for civil and other military provincial service both recruited by competitive examinations open to all university graduates and licentiates of medical schools.

13. Unless the rank has some official capacity the present rank of warrant officers leaves very little to control the hospital menial staff which makes the work of sub-assistant surgeons extremely difficult. No power has been entrusted to a medical subordinate for the present as a warrant officer and it is highly necessary simply to maintain discipline in hospital that sub-assistant surgeons should have a commissioned rank which will bring Indian station hospitals to the rank of British army hospitals.

14. Civil sub-assistant surgeons would be prepared to undergo military regulations, only if they are allowed the rank of Indian commission and honorary British commission and all privileges that are enjoyed by Anglo-Indian assistant surgeons. Rules compelling them to act as warrant officers will make the recruitment of civil service unpopular; none would like military service.

15. This will produce difficulty in getting sufficient hands in the department. If optional volunteering is secured with an attraction of some special military allowance without making the service unpopular Government will have a number of civil hands in their employ, ready to join field service in times of emergency. The rules in this department should be in no way different from other departments like Post, Public Works, etc., who also require their civil hands for military duty in times of need.

Dr. SURJU PERSHAD, called and examined.

(Mr. Hignell.) He was General Secretary of the All-India Sub-Assistant Surgeons' Association. The headquarters of the Association were in Bombay, though he himself remained at Indore. The whole of India was represented on this Association which had been in existence for 14 years, and was recognised by Government. Its members totalled about 3,000. The rank of warrant officer given to a sub-assistant surgeon in the Indian army was unsatisfactory. He suggested that they should be given commissioned rank.

The taking of bonds from sub-assistant surgeons was unpopular and should be done away with. He suggested a retaining fee of Rs. 10 or Rs. 15 a month to civil sub-assistant surgeons in order to encourage them to volunteer for military duty in cases of emergency. This retaining fee should be granted on the condition that they would be liable for military duty when necessary. He could not give a guarantee that they would all go on field service even after they had received this retaining fee. If they refused to go they should be tried under the Army Act.

(General Hehir.) Military sub-assistant surgeons were not treated at all well. First grade men should be given commissioned rank, and the rank should carry with it all the privileges connected with it. In order that they might be fit for commissioned rank they should be given military training in a school.

In order to keep up the reputation of civil hospitals military sub-assistant surgeons, who had been away from civil for any length of time, should not be given appointments in civil hospitals.

He was of opinion that Government should raise the standard of education for sub-assistant surgeons in order to get their qualifications registrable under the British Medical Act.

The prefix "sub" should be done away with in military service, as it conveyed no meaning. He did not think they would be satisfied if they were called "Jemadar, Indian Medical Department," etc.

(General Hendley.) They were quite satisfied with their designation in civil.

Only a very small number volunteered for military duty out of 3,000 members in his Association. He had tried repeatedly to get them to volunteer but failed.

He was not in favour of lectures in the various medical schools being given in the vernacular.

(General Giffard.) The Association had a family pension fund but it was local. Each member subscribed Re. 1 to the fund, and in the event of a sub-assistant surgeon dying, his widow gets Re. 1 from each member of the fund.

His belief that men would volunteer for military duty if they received a retaining fee was based on the fact that for four appointments on a hospital ship there had been 150 applicants.

20 March 1919.]

The Hon'ble Colonel C. R. M. GREEN.

*(The schemes and questions referred to by witnesses are contained in Volume III.)***At Bombay, Thursday, 20th March 1919.****PRESENT:****S. R. HIGNELL, Esq., C.I.E., I.C.S. (Presiding.)****MAJOR-GENERAL G. CREE, C.B., C.M.G., A.M.S.****MAJOR-GENERAL P. HEHIR, C.B., C.M.G., C.I.E., I.M.S.****MAJOR-GENERAL H. HENDLEY, K.H.S., I.M.S.****THE HON'BLE MAJOR-GENERAL G. G. GIFFARD, C.S.I., I.M.S.****LIEUTENANT-COLONEL A. SHAIRP, C.M.G., Indian Army.****MAJOR M. T. CRAMER-ROBERTS, D.S.O., Indian Army.**and, as co-opted members **SIR T. NARIMAN, Kt., the HON'BLE COLONEL H. E. BANATVALA, C.S.I., I.M.S., and LIEUTENANT-COLONEL BHOLA NATH, C.I.E., I.M.S.****MAJOR A. A. MCNEIGHT, I.M.S. (Secretary).****The HON'BLE COLONEL C. R. M. GREEN, M.D., D.P.H., F.R.C.S., I.M.S., Inspector-General of Civil Hospitals, Central Provinces and Berar.***Written statement.**Answers to questions regarding Medical Stores Department.*

1. Stocks of drugs and instruments of local and civil dispensaries and civil hospitals, not wholly supported by Government, in these provinces, are replenished—

(a) principally from Ferris and Co., Bristol and Down Brothers, London,

(b) from firms in Calcutta and Bombay.

2. The responsibility for indenting rests with the Inspector-General of Civil Hospitals. The suggestion of having Government Medical Stores as sources of supply is obviously sound. Increased manufacture in India should be easily arranged. There might be an objection to all stores being obtained from the Medical Store Depot on the ground of interference with private enterprise and the encouragement of local industries. This would be obviated by the Store Depot employing firms in India.

3. I have no suggestions to make in connection with the working of the Medical Store Depots.

Answers to special questions.

1. The demands of European members of the public services for European medical attendance on themselves and their families are based chiefly on racial predilection; this includes the question of professional merits.

2. Europeans have not been satisfied with the medical treatment received from Indian substitutes for European medical officers withdrawn. They have met the difficulty (1) by putting up with it and sacrificing their feelings as a war necessity, (2) by going when able to where they could get a European doctor.

3. (a) The sub-assistant surgeon is very necessary on account of his cheapness and lower standard of living. Of course there are exceptions but the average sub-assistant surgeon in civil is inefficient and becomes more so with length of service. He is good only as an assistant to a superior officer. The average civil assistant surgeon tends to improve with years and is efficient.

(b) Assistant surgeons in recent years have deteriorated in efficiency in my opinion. When they were fewer they were brought more in touch with the European teacher and had more attention. No doubt now, out of the increased members, there are individuals far better qualified.

Questions for witnesses.

1. (a) I favour scheme B because it is a compromise and will probably be less difficult to work than an entirely new scheme.

(b) It makes provision for the Director, Medical Services, to be selected from the Indian Medical Service, thereby removing a legitimate grievance.

(c) It makes provision for an advisory board and a medical staff college.

(d) It abolishes the area allotment, which in these days is an absurd arrangement.

2. It should meet with the approval of the War Office and will meet the needs of the army in India.

3. I think that the scheme will attract a good stamp of recruit and meet the demands of professional opinion in England and in India.

4. By the withdrawal of European medical officers from civil districts, the effect has been discontent on the part of European's increased trouble with the subordinate establishment, an increased number of cases of corruption (rumours more than proved charges), decreased amount of good surgery, decrease in sanitary and general efficiency and a lowering of the status of the State medical service.

5. It will meet with the present needs of the civil administration. In case of war there would be less dislocation owing to the increase in the cadre.

6. I think it would give an efficient reserve but not sufficient. Private practitioners who are yearly increasing in numbers should be enrolled in case of a big war.

7. A medical service reserve for war, previously trained in military duties, is an advantage but not a necessity. The reserve should be in India.

8. Its members were put into every kind of military appointment there was in the medical department and the instances in which they failed were very few.

9. Recruits should have a European training; the system at present in force is sufficient.

10. Study leave should be compulsory, at least six months should have to be done at post-graduate courses twice in the course of the first twenty years.

11. Any person selected for the research department should be "on probation" the first year, so that he could be reverted, in case there was want of aptitude for that kind of work.

12. Private practice has declined and must eventually disappear, except in large centres where there will be some Indian consulting practice and practice among Europeans. The reasons are:—

(1) The growth of the independent medical profession.

(2) The large increase in the amount of work a man in civil has to perform, giving him less and less time for other than Government work.

(3) Too frequent changes of officers, and

20 March 1919.]

The Hon'ble Colonel C. R. M. GREEN.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

- (4) The competition at lower rates of the assistant surgeon—civil and military—serving in district and of retired medical officers of all classes.

Questions to be asked of service officers.

1. I have been six years in military service and 26 years in civil service, total 32 years.

2. As Inspector-General of Civil Hospitals, I have not the right to see the Chief Commissioner officially. In practice there is no cause of complaint under this head owing to the courtesy of the Chief Commissioner who grants interviews whenever asked for. The posting of civil surgeons are not gazetted under the signature of the head of the medical department. This lessens his prestige and control over officers. Our clerks are less well paid and the head of the office is not of gazetted rank. As a result my office occupies a position of lower standing than others. I am of opinion that the head of the medical department should hold the status of a Secretary to the Administration.

3. I have not met with any instances of friction between the Royal Army Medical Corps and Indian Medical Service except the supersession of Indian Medical Service Officers by junior Royal Army Medical Corps officers in the Waziristan Expedition of 1917, and such, I heard, was prevalent on all fronts. The complaint was that if there was any special duty out of the usual line, but not attractive from the honour or pecuniary point of view, then an Indian Medical Service officer was put in.

4. A unified service if practicable, or if not, then the better and more complete training of the Indian Medical Service in the station hospital system and war conditions so that they would have a fair opportunity of acquiring knowledge in these subjects. Even the military side of the Indian Medical Service had no training in the station hospital system and it is creditable the way in which they picked it up. I would make every Indian Medical Service officer serve in a British station hospital, say for three months and every Royal Army Medical Corps officer serving in India, in an Indian station hospital for a similar period, if a unified service is not introduced.

5. Two years should be fixed as the limit of service for transfer from military to civil employment and 20 years should be fixed for transfer from civil to military.

Questions to be asked of officers regarding assistant surgeons and sub-assistant surgeons.

1. The form of bond prescribed in these provinces for sub-assistant surgeons is attached.* No alteration has been made in it during the war. No change is recommended from the civil point of view. A retaining allowance might induce some to undertake military duty out of India or the promise of warrant officer's rank and pay. The conditions at present laid down were enforced by the dismissal of sub-assistant surgeons who refused to go on military duty and by ordering payment of Rs. 400 secured by the bond.

2. It would not be possible to make the bond renewable without seriously affecting recruiting, unless it was voluntary and a special inducement was offered.

3. There should be a time scale of pay for sub-assistant surgeons rising from Rs. 50 to Rs. 150 by biennial increments up to Rs. 130 and then by selection from amongst those who have put in service of 15 years and over to the senior grade divided into two classes on Rs. 140 and Rs. 150. A proposal to this effect has recently been submitted to the local administration.

4. The province could supply civil assistant surgeons to the extent of 50 per cent. as more men of this class are available and sub-assistant surgeons to the extent of 25 per cent. only without a serious dislocation of the medical and sanitary services. The number employed could be advantageously increased by the opening of more mofussil dispensaries, travelling dispensaries, by the increase in the number of the leave reserve and by the

placing of the more important outlying dispensaries in charge of assistant surgeons instead of sub-assistant surgeons. There was much dislocation of work by the withdrawal of sub-assistant surgeons for military work, e.g., a number of dispensaries had to be placed in charge of compounders and in visiting charge of neighbouring assistant or sub-assistant surgeons, travelling dispensaries had to be closed down temporarily and the medical subordinates on plague and other epidemic duty under the Sanitary Commissioner had to be utilized elsewhere to a great extent.

5. Civil assistant surgeons in these provinces are required to sign an agreement bond a form of which is attached.* Under this agreement they are bound to serve for five years within India in civil employ. It should be voluntary to agree to serve in or out of India in the military department and an inducement should be offered in the shape of a promise of a commission as a temporary Indian Medical Service officer in case of necessity.

6. (a) The ordinary medical requirements of the general population and of the State are not satisfactorily met by present arrangements and a great increase is required in the establishment. It is a question of finance.

(b) No change in the matter of control or supervision is necessary.

7 and 8. No reply.

9. No reply.

10, 11 and 12. No reply.

13. Retired military assistant surgeons were of great use in the civil department.

14. The number of military assistant surgeons in civil employ should not be more than at present.

15. I am of opinion that a military assistant surgeon should have a registrable qualification and should not be further recruited until this occurs.

16. I would be in favour of continuing to recruit the military assistant surgeon class if his education was raised to the standard required to obtain a qualification registrable in India, e.g., the membership of the State Faculty of Bengal.

17. Military assistant surgeons so educated will be employed as civil surgeons for a certain proportion of the small stations, assistant to civil surgeons, sub-divisional medical officers in the sanitary department and in appointments on State and guaranteed railways.

18. I have no suggestion to make in connection with his conditions of service.

Questions for representatives of Local Governments (not to be considered as representing the views of the Administration of the Central Provinces).

1. (a) The compulsory military training of some portion of civil assistant and civil sub-assistant surgeons cadres would require a large reserve for leave purposes. The cost of this should be a charge on the military department. To prevent dissatisfaction, a special retaining allowance should be given for liability for military service in or out of India. The acceptance of this liability should be voluntary.

(b) Government would be contented to continue to give Indian Medical Service military officers all superior appointments. The needs of the Administration are for the services of well qualified Europe trained medical officers with a large proportion of Europeans in it to administer the Medical, Prison and Sanitary Departments, certain special appointments and for the more important civil surgeoncies of districts, specially the divisional headquarters. These are economically and efficiently supplied by the loan of the services of officers from a distinguished and popular military medical service such as the Indian Medical Service has been in the past. This service is not a European service and is open to Europeans and Indians alike and it is open to any Indian to enter this service if he desires State service. He would have to qualify in Europe if he desired to belong to the first rank of practitioners out

*Not printed.

20 March 1919.]

The Hon'ble Colonel C. R. M. GREEN.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

here. So the fact that he has to compete in England for the Indian Medical Service is no disability. This system has also furnished an invaluable war reserve which when tested in the late great war has failed only in that the reserve of European medical officers was too small. Therefore any system for the formation of an unified medical service does not concern this administration, as long as the pre-existing system of obtaining European military medical officers is not interfered with.

2. Government consider the increase of officers in superior appointments in civil cadre would be more satisfactory from the Indian Medical Service.

3. They are prepared to make it a condition of appointing an outsider in higher appointments that the officer should belong to the second reserve. Government consider that military medical officers are *ipso facto* better in the superior appointments than pure civilian doctors. The reasons are that service officers are more under discipline. Leave and replacement can be more easily arranged for. From a service of over 700 doctors, specialists of the first rank can be obtained in all subjects. They are less expensive than European civilians of a like fitness and they come to these provinces knowing something of the language and customs of the people.

4. Government does not consider that in future a reserve could be formed from the independent profession except by giving a retaining allowance in peace time that need not be large.

5. Government have found that the present leave reserve in civil employ is not numerically sufficient to ensure that medical officers get all the leave which is

due to them under the Civil Service Regulations and also the study leave.

6. The effect would be bad on the recruiting for Government service unless large allowances were given to replace the loss caused by giving free treatment to the families of all civil officers in the outlying districts of the province.

7. As regards free hospital treatment in selected centres to the families of all the officers in the various civil services, provision of accommodation should be made for such, but there should be hospital stoppages or it will lead to abuse.

8. Government would not be in favour of appointing two or more travelling consultants and travelling medico-legal experts in the province. There is no need for them.

9. Government would be prepared to allow Indian Medical Service officers in civil employ to return for one year, at the end of each five years, to the army. A larger reserve would be necessary and a special sum given to the officer for the expense of breaking up establishment.

10. No arrangement to meet the legitimate aspirations of Indian graduates towards a larger share in the superior civil and superior medical educational appointments is necessary. The Indian Medical Service is not an European service. The existing system in the Central Provinces permits of certain districts being held by other than Indian Medical Service officers.

11. There has been a falling in quality of the civil medical work done since the Indian Medical Service officers were recalled to military duty and their civil duties handed over largely to civil assistant surgeons.

The Hon'ble Colonel C. R. M. GREEN, called and examined.

(Mr. Hignell.) If, as a result of legislation to secure control over the manufacture of drugs, and to ensure their purity, British firms of standing and repute were induced to open large depots in India and also to start the manufacture of indigenous drugs, there would be fairer competition between the firms from which the store depot could get its supplies.

There had been a great decline in the practice of Indian Medical Service officers in the mufassil, but not in Calcutta.

In the early days of his service every Indian Medical Service officer should serve in a British station hospital, for about three months, and every Royal Army Medical Corps officer serving in India in an Indian station hospital. No doubt Indian Medical Service officers in military employ would be serving all along in Indian station hospitals, which would be run on the same lines as British station hospitals, still it would lead to better feeling and keep up their efficiency if the above suggestion were accepted.

(General Hahir.) Throughout the service there should be constant pooling in peace time as was the case in war time.

(Mr. Hignell.) He agreed with the complaint of the military authorities that officers, who took up military duty after a long period spent in civil employ, were not fit for high administrative posts and that three or four months' training was not sufficient to fit them for this purpose. Even those in military service had not a fair chance. Indian Medical Service officers were not trained for this, but the same disability would not exist later on, if they were trained in the earlier period of their service. He himself had been 27 years in civil. On joining the military he went to the station hospital, Bombay, where he chiefly studied problems of distribution. When he went to the frontier as Assistant Director, Medical Services, he had never seen some of the units he had to administer, and did not know what a clearing hospital was. Within three weeks of his arrival there he had to go on field service. He strongly condemned the system in vogue hitherto. On the frontier he was quite isolated in his own brigade in which there were no British troops. It was the general complaint that Indian Medical Service officers were frequently

sent to such places, where they had no opportunity of gaining experience with British troops, and yet on service they were held responsible for everything. This difficulty would be got over by the reversion of officers from civil to military at regular intervals, and by the introduction of the station hospital system for Indian troops, and by the permanent reversion to military at 20 years' service of officers who were to fill military administrative posts. It would increase the efficiency of the service if officers in civil were not promoted to higher military rank than that of lieutenant-colonel.

The bonds for civil sub-assistant surgeons had been useful in the recent war, as the fact that refusal to go on military duty entailed the payment of a heavy fine deterred many sub-assistant surgeons from disobeying orders.

The idea of starting travelling dispensaries was a comparatively new one. At present there were some under the Sanitary Commissioner of the Central Provinces and some under the Inspector-General of Civil Hospitals. An increase in their number was contemplated when war broke out. It was very difficult to manage them on account of the dearth of doctors. Indian sub-assistant surgeons would not go out into the jungles, and he had been compelled to employ compounders, and to put them in charge of small dispensaries. There was a great scope for the expansion of this scheme of travelling dispensaries, which was of great benefit in bringing medical relief to the poorest villagers. They were also useful in sanitary work.

(General Hendley.) They were used all the year round, but would be particularly useful in the case of an outbreak of cholera, plague or influenza. These dispensaries were under the civil surgeon.

(Mr. Hignell.) With regard to the complaint of the civil assistant surgeons that military assistant surgeons had more than their share of civil surgeoncies, he explained that this was due to racial reasons. In the smaller civil surgeoncies a military assistant surgeon, who was familiar with the habits and customs of Europeans and was sometimes a white man, was more popular. Again they could be more useful in sanitary appointments and in the jail department as they had more force of character and power of command than

20 March 1919.]

The Hon'ble Colonel C. R. M. GREEN.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

Indians. It must be admitted however, that though some of the military assistant surgeons were very good professionally, still as a whole Indian graduates were better.

He agreed with the views of the Central Provinces administration, as contained in their note.

(General Hendley.) Sub-assistant surgeons were anxious to obtain better qualifications and to become the equals of assistant surgeons. The need at present was for doctors of lower status, and for a larger number of more lowly qualified medical men. He himself had been compelled to employ compounders for want of sub-assistant surgeons. He did not consider it a retrograde step. It was difficult to get sub-assistant surgeons for small villages as they were trying to become full-fledged practitioners equal to assistant surgeons, and he had been compelled to employ compounders. He had offered pay at Rs. 60 a month for sub-assistant surgeons, but was still unable to get them. There was a deficiency of 75 in the cadre. The medical school that they had could turn out but a few, and the Central Provinces had to depend for their requirements on other provinces. There used to be a bigger school which had been closed.

Assistant surgeons had deteriorated in efficiency in recent years as they did not come in touch with European teachers as before. The personal influence of the teacher was of the greatest importance, and had a wholesome effect on character. The larger size of the schools made this more difficult. When there were fewer students in a class they had greater opportunities of coming in personal contact with their teachers. It would not be possible to secure this in the present state of political feeling if more Indians were to be placed on the teaching staff. The employment of a larger number of Indians on the professorial staff would have an adverse effect on the standard of medical education and professional efficiency. It could only be remedied by having more medical schools with a larger element of Europeans on the teaching staffs.

One of the effects of the withdrawal of Indian Medical Service officers during the recent war had been that there was trouble with the subordinate establishment. There had been great difficulty in exercising control. Assistant surgeons acting as civil surgeons did not like to be ordered about, and the subordinate staff did not show the same loyal obedience to them as they did to gazetted medical officers. There was considerable friction in the staff, and want of discipline. There had frequently been cases in which sub-assistant surgeons objected to being placed under Indian assistant surgeons.

Two years should be the limit of service for transfer from military to civil employ. The only practical way of giving effect to this would be an increase in the number of civil appointments. The earlier an officer was transferred to civil the better. His experience had been that it was deadening to stay too long in military.

(General Hehir.) He did not approve of the suggestion to have store depôts at all provincial headquarters. Nor would it be well to lay down any hard and fast rule that store depôts should only stock non-deteriorating drugs and that other articles should be obtained from local firms.

The fact that the Director, Medical Services, had always been a British service officer had created a bitter feeling, and was a constant grievance with the Indian Medical Service.

If all the grievances of the Indian Medical Service were removed, and the co-operation of the deans of the medical institutions in the United Kingdom were secured, it would be possible in time to restore the service to its former popularity, though it was bound to take a long time to remove all the discontent. With the present political unrest this would not have any immediate effect on recruitment, and at least seven years would elapse before any good effect could be produced.

(General Giffard.) Under the present conditions he would not advise a young man to commit himself to service in India for the next 30 years. To make it possible for him to do so the pay of the Indian Medical

Service would have to be increased, and their position would have to be improved. They had many grievances which would have to be removed. The attractions on the civil side would have to be greatly improved. The work of the civil surgeon was increasing, and it often happened that he was the only white man in the district, and thus had to lead a very isolated life. However good his prospects social isolation was a great drawback.

There would be great difficulties in the way of unification. The service might be improved sufficiently on the military side, and also in time on the civil side. If, however, anything was to be done in the direction of unification this was the proper time to do it. If all the improvements asked for were at once sanctioned by the Secretary of State, he did not see any objection to young men committing themselves to service in India for the next 30 years, as they could resign if they found that conditions of service were not suitable.

(General Hehir.) The proportion of three medical officers per mille for Indian troops was not excessive.

The fact that the Inspector-General of Civil Hospitals could not gazette the postings of civil surgeons lowered his status. A medical officer should command his own department.

One secretary dealt with several departments, and he himself had to deal with two secretaries.

His remarks regarding the recruitment of military assistant surgeons in paragraphs 15 and 16 of his written statement were made from the civil point of view.

If private medical practitioners were given temporary commissions and certain other privileges, and a retaining fee, they would be willing to join a war reserve.

Unless suitable inducements were offered, the laying down of a condition that all assistant and sub-assistant surgeons should form part of the war reserve would adversely affect recruitment.

The independent medical profession was not fit to carry out efficiently the duties entrusted to Indian Medical Service officers in the various appointments which they held, nor would they be able to carry out as efficiently the teaching work in medical schools and colleges.

(General Giffard.) Professorial appointments were open to Indians as well as Europeans. To obviate the occasional difficulty when cadre appointments could not be filled from anybody in the service he would have a sort of special inner cadre, and place professorial appointments on the same footing as jail appointments. He would prefer a pooling of a reserve of the service for educational purposes, and to keep teaching appointments within the service. There should be an Imperial rather than a Provincial cadre. There should be a due proportion of Europeans in the cadre. At present Indians had no grievances. They could enter the Indian Medical Service, if they liked, if they wished to be in the front rank. If they were in the lower State service they could join the assistant surgeon class.

With regard to the complaint that an assistant professor, who had served as such for a long time, could not succeed to the professorship, as he belonged to a subordinate service, he was of opinion that subordinates should not be employed as assistants. There should be a special cadre for such appointments, as there was for jail appointments. There should be an understudy for each appointment.

(General Hehir.) The nursing of Indian soldiers in military hospitals was most unsatisfactory. It would be impracticable to employ members of the Queen Alexandra's Nursing Service in Indian station hospitals in smaller stations, but their services could be utilized in bigger hospitals. They might be employed on supervision and training work and also for nursing duties in the bigger hospitals.

(Colonel Banatvala.) There were no difficulties in the way of nursing in a hospital attached to a big medical college, where there were English as well as Indian nurses looking after European and Indian

20 March 1919.]

The Hon'ble Colonel C. R. M. GREEN.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

patients. Both Europeans and Indians were treated alike, and there had never been any trouble. It would not be necessary to have a subordinate staff of nurses if there were a sufficient number of sisters to supervise the wards, and if there were orderlies to carry out the minor duties. In civil hospitals such orderlies were not available and all nursing duties had to be done by the nursing staff. That was why he did not think it proper to employ nursing sisters in civil hospitals. There might, however, be a superior class of nurses to supervise and train others, there being one or two in each large hospital. The superior nurses might occasionally be utilized to nurse officers in big stations.

(General Hehir.) He would recommend the formation of an advisory board for the selection of Indian Medical Service officers to fill superior civil appointments.

British and Indian station hospitals in the same station could be worked under one administration, and one organization that is to say, under one commanding officer, though there might be some trouble if an Indian were in charge of the British station hospital.

(Colonel Bhola Nath.) He had heard of no complaints in cases when during the war a number of Indian Medical Service officers had been placed in command of large combined hospitals.

(General Hehir.) Complete medical education was obtainable in India.

(Sir T. Nariman.) In case an Indian and a British candidate, with the same qualifications, joined the Indian Medical Service he would not say that the Indian candidate would not be as fit to hold a professional appointment as the British candidate. He himself had known of some Indians who were quite fit to hold such appointments.

Civil Assistant Surgeon E. S. BEARUCHA, L.M. & S., KHAN BAHADUR, Assistant to the Civil Surgeon, Poona.

Written statement.

The present organisation of the medical services in India was evolved at a time when India was entirely or to a great extent reliant upon medical men from England. Occasional alterations or improvements in matter of details might have been carried out from time to time but no radical changes appear to have either been contemplated or effected for at least the past fifty years in the constitution of the different branches of the medical services. Since those days considerable progress has occurred in the matter of the spread of western medical education amongst the children of the soil, credit for which is entirely due to the Indian Medical Service. But with the progress so effected, it is but natural that the aspirations of the local men have also increased. One notices with dismay that in the four alternative schemes before us little or nothing seems to have been attempted to satisfy those legitimate aspirations of the Indian medical graduates. I would make myself clear by stating at once that in any reorganisation to be effected hereafter, I recognise fully the importance of the existing rights and privileges of all officers, be they Indian Medical Service men or civil or military assistant surgeons. In evolving a new scheme of re-organisation one must, therefore, bear in mind that fact and then proceed not haltingly but boldly to recognise the merits and abilities of the Indians. No scheme therefore that is evolved without due consideration of these two factors could be acceptable to the Indian medical profession. Let us then see how far the four alternative schemes that have been circulated for opinion satisfy these points.

I feel I am not sufficiently conversant with facts to make any statement regarding the advisability or otherwise of unifying the different medical services, but this much can be said with certainty that none of the four alternative schemes will help to satisfy the legitimate aspirations of Indians. After a careful study of them all I am inclined to believe the scheme A is perhaps the only one most likely to be accepted as tending to go in that direction with certain reservations. The institution of an auxiliary corps to be recruited from amongst Indians and Anglo-Indians under the conditions suggested in that scheme, appears to me to be the one likely to meet with approval as it aims amongst other things to ensure a substantial proportion of Indians getting the opportunities of entering the Royal Army Medical Corps. That would be more so if steps could be taken to recruit these men by competition both in India and in England. 50 per cent. of these should be obtained from graduates of the Indian Colleges recruited after a special competitive examination held either in Calcutta, Bombay or Madras, the remaining 50 per cent. from England direct.

The most attractive part of scheme A, however, is with regard to the "Civil Medical Service." As to the advisability or otherwise of creating such a service, I am sure, speaking as I do on behalf of the provincial medical service, it will meet with universal satisfaction. I cannot agree with the remarks in paragraph 16 of

scheme B on this point. I do not know what Sir Mahadev Chaubal's views in the matter may be at present; however, the events of the past four years go a long way to support his very strenuous remarks on the subject. The ready response by the Indian graduates who volunteered in such large number to serve in the different theatres of war has proved to the hilt the questionable advantages of a war reserve in time of national emergencies, such as the one through which the British Empire has emerged so successfully. The services rendered by the Indian graduates will remain a proud record for them for all time to come. Most of the 800 if not all of the temporary commissioned appointments were held by the volunteer graduates from the different Indian universities. This number was in addition to at least 75 per cent. of the total of the civil officers of the Indian Medical Service surrendered to the military department. The war has proved beyond doubt the inadequacy of the so-called war reserve. To maintain a sufficient reserve for war purposes of the kind we are just passing through, the strength of both the Indian Medical Service and the Indian Medical Department (military assistant and sub-assistant surgeons) should be enormously augmented. We may take it that with the establishment of the league of nations and peace conditions such as are being now threshed out combined with the fact that the war energies of all nations have now got considerably depleted, such a necessity as the one we have experienced in the past four years is not likely to arise, let us hope, for generations to come. In fact I am of opinion and sanguine enough to hope that before such another grave crisis should arise again medical education in this country will have extended in due proportions and there will be created a much larger reserve, spontaneously, to encourage which, instead of spending large sums of money on reserve of the kind contemplated, in my humble opinion, more colleges and schools should be established. That would result in a potential increase in the number of qualified men in this country who, I am sure, will, if emergencies arise, volunteer in sufficient numbers and there would be no difficulty in getting suitable men then as occurred in the present war.

The creation of an entirely separate Indian civil medical service not dependent perpetually on military requirements of a high standing is thus a pressing and an urgent necessity. Scheme A though not entirely to a certain extent meets this desideratum. Such a scheme has been practically unanimously approved of by the Public Services Commission and steps should be taken to bring their recommendations into force at an early stage. I do not see why there should be any necessity of 10 per cent. of men from the Royal Army Medical Corps to be seconded for this Indian civil medical service. The scheme definitely lays down the method of recruiting the civil medical officers besides the 10 per cent. of the reserve. This leaves ample

20 March 1919.]

Civil Assistant Surgeon E. S. BHARUCHA.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

scope for European medical men "who would form a part of the permanent whole-time service." By reserving the 10 per cent. of these appointments to Royal Army Medical Corps men the scope of appointments for Europeans will be thus disproportionately increased to the disadvantage of Indians.

I would propose that two sets of competitive examinations be laid down for medical services in India, viz., 1st for purely military services in India to form the auxiliary corps of the Royal Army Medical Corps to be recruited from Indians and Anglo-Indians. (These will be distinct from the purely European members forming the Royal Army Medical Corps.)

The examinations could be held simultaneously both in England and in India or better still in India alone as the candidature will be restricted to Indians and Anglo-Indians only.

2nd the Indian civil medical service should be of three grades (a) Imperial, (b) Provincial, (c) Subordinate.

The recruiting in class (a) should be by (1) competitive examination held in England, (2) competitive examination held at a convenient centre in India and (3) by promotion of a certain percentage from the civil provincial medical service.

I would suggest 50 per cent. should be recruited by the 1st method, 25 per cent. by the second and 25 per cent. by the third. Preference in the case of the last should be given to men who have attained special distinctions since their entertainment in the provincial service by either taking the M. D. or equivalent degree of any of the Indian universities or by having taken a post graduate course in England and obtained a British diploma. Special facilities for such post graduate course should be given to such men.

As a point against men recruited by the last two methods may be argued that they will not be of the same mental calibre and standing as those recruited directly in England. My reply to that will be that in most cases these men will be the pick of the colleges of India, men in all cases above the average. Our colleges are now fully equipped for the study of all branches of the medical science and it would be not only a poor recognition of the merits of our students but a still greater slur on the administration of our colleges if such an argument is allowed to pass unchallenged. The late lamented Lieutenant-General Sir Pardey Lukis and Surgeon-General Lyons both of whom had a first hand knowledge as professors of the colleges to which they belonged of the capabilities of the institutions and the students that passed through their hands have very generously stated in their evidence before the Public Services Commission that the teaching in the Indian medical colleges if not superior, can stand a favourable comparison to that of colleges in England. If so, I cannot see what objections could be raised at the examination being held simultaneously in India and England. I am inclined to think on the contrary that a student trained entirely in India would be of greater value almost from the commencement of his career, he being not only conversant with the languages, habits, customs, manners, etc. of Indians, but what is more, he will be equipped with more practical knowledge of diseases peculiar to India and the tropics which a man recruited from England cannot be expected to have and which he will have first to learn and familiarise himself with on his arrival in this country. As a safeguard I would have it laid down, if thought necessary, that such men should have some European training, they may be sent for a post-graduate course to England after selection. This period of service would be analogous to that of an officer directly recruited in England and spending the first few months of his service in familiarising himself with Indian conditions.

In this connection I would like to point out that recruiting in some of the higher grades of the Financial Department of India is now carried out by annual competitive examinations in India and in the Public Works Department at least in this Presidency one appointment used to be reserved annually for a local graduate who stood first at the university examination without any competitive examination. These men ranked in the Imperial service and as far as I am aware enjoyed

all the privileges of that service. I know of some of them who have never even once visited England and have creditably conducted themselves in such high appointments as superintending engineers. If that is so in the case of the science of engineering which is as technical as that of medicine it is but reasonable to expect the same would hold good in the case of the latter.

(b) *Provincial.*—The recruiting in this class should be from graduates of the universities as at present to which I should add also such of the members from the subordinate medical department as have passed the membership of the college of physicians and surgeons. I am of opinion that many new and more useful appointments could be created in the service by possibly eliminating a few from their cadre as it now stands. I think in the present advanced state of medical science, requiring a good deal of technical skill for the diagnosis and treatment of diseases and for the efficient working of civil hospitals on modern lines, each civil surgeon or at least first class civil surgeon should be given the help and benefit of an assistant of higher training than that of a sub-assistant surgeon. In fact each civil surgeon should have an assistant to civil surgeon who should be a member of this class of officers. This practice actually exists in some provinces, e.g., Central Provinces, and could be advantageously followed both here and in other provinces. A civil surgeon in these days has more manifold duties to perform than in the past. All the district administration is now-a-days entirely in his hands and in such civil surgeoncies as have a district jail or lunatic asylum a good deal of his time has to be devoted to that work. Such an arrangement would not only be conducive to better attention being given to patients but to my mind it would indirectly stimulate research and knowledge which in the case of such hard-worked officers as the civil surgeon would only be attained by a greater division of work entrusted to trained men of superior mental calibre.

I would here like to allude to one other point. Members of the provincial service would resent any attempt to have their class mixed up with that of the military assistant surgeon. I have no remarks to offer regarding their status on purely military service but so long as the training and qualification of these officers remain as at present their amalgamation in any form in the provincial civil medical service would be highly objected to. For their amalgamation with either the provincial or superior service one condition should always be that they hold a degree or diploma recognised by the General Medical Council like that of the university graduates.

(c) Recruiting in this grade should be carried out in the same way as at present from amongst the men of the provincial medical schools who qualify by obtaining the licenses of the college of physicians and surgeons of Bombay or a diploma equivalent to it from other parts of the country. Such of the men as obtain the membership or higher diploma may be promoted to the provincial service either at once or after a fixed period of service.

Questions to be asked of officers regarding assistant surgeons and sub-assistant surgeons.

1. Most of the civil sub-assistant surgeons get their training at Government expense. They give a bond to serve Government on qualifying at the time of entrance to one of the provincial schools. On passing and entering service another bond is taken from them. This practice has been followed for many years now. As far as I know there has been no alterations in the term of the bond during the war beyond increasing the penalty to Rs. 1,000. I do not recommend any change in the bond. According to the present form a civil sub-assistant surgeon is bound to serve Government within India in civil or military department for a period of five years. If that is extended to serving out of India it will to my mind affect recruiting considerably unless their pay and prospects are substantially improved and I am doubtful of it even then. The conditions at present laid down have, so far as I know, proved adequate to their enforcement. A certain

20 March 1919.]

Civil Assistant Surgeon E. S. BHARUCHA.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

number, however, prefer to pay the penalty laid down and resign rather than go on military duty even in India and a very large number positively refused to go on overseas service. 21 civil sub-assistant surgeons were dismissed for refusing to go on military service (*vide* Annual Report of Civil Hospitals and dispensaries for the year 1917).

2. I do not think so, but it would be possible to increase the period from five to seven years as is the case with the bonds of military sub-assistant surgeons.

3. I do not think the conditions of service are satisfactory. There is a great deal of discontent amongst the men especially *young men* as in recent years the standard of preliminary education is raised as well as the course of study is increased from three to four years and every body has compulsorily to take the license of the college of physicians and surgeons to qualify. The best way to amend these conditions is to offer better pay and to find openings for promotion to the provincial service for such men as have passed the membership of the college of physicians and surgeons.

4. Taking the case of assistant surgeons our experience during the great war has been that there was no difficulty in obtaining any number of assistant surgeons to replace those who volunteered for military service, and those promoted to officiate as civil surgeons to replace the Indian Medical Service officers recalled on military duty and also to officiate in the various appointments as those of house surgeons and civil surgeons held by military assistant surgeons recalled. The same cannot be said regarding civil sub-assistant surgeon. Their being drafted on military duty to a certain extent dislocated the civil medical department. Some of the dispensaries had to be closed down temporarily and some appointments in civil hospitals had to remain unfilled, throwing greater strain on the depleted staff left behind.

I am of opinion that a certain number of extra civil assistant surgeons could be advantageously increased. I think in the present advanced state of medical science, requiring a good deal of technical skill for the diagnosis and treatment of diseases and for the efficient working of the civil hospitals on modern lines, each civil surgeon or at least 1st class civil surgeon should be given the help and benefit of an assistant of higher training than that of a sub-assistant surgeon. In fact each civil surgeon should have an assistant, recruited from the graduates of the university. This practice actually exists in some province, *e. g.*, Central Provinces where the civil surgeon has an assistant surgeon under him who is a great asset for emergency surgical, medico-legal and other similar works. This is more so now, as the district work which formerly used to go to the Surgeon-General is now done by the civil surgeon and would be particularly wanted in civil surgeoncies with district jails requiring a good deal of the civil surgeon's time for jail work. The number of sub-assistant surgeons could also be advantageously increased; more dispensaries are needed and will in course of time be opened in all districts.

5. Yes, but unless substantial improvement in their pay and prospects is brought about, there would be great difficulty in recruiting and getting suitable men for this class. They should be bound for the whole time of the service and not for a particular period only. In this connection I would invite attention to the answer given by assistant surgeon Ghaswala to a question put to him during his examination before the Public Services Commission, *vide* para. 58200, page 211, Volume XII of the Minutes of Evidence relating to Medical Services. He says 'he would provide for the war reserve for which the civil surgeons were at present considered to be necessary by *compelling* all civil assistant surgeons to give a bond to serve during war, and *they should be given the necessary training to fit them for a campaign*. He was supported by a large number of civil assistant surgeons in that view.

6. This question has to a certain extent been answered above (*vide* query 4). More dispensaries are needed, and civil surgeons or at least the most heavily worked of them should be given more efficient help in the shape of assistants to civil surgeons. I would

certainly abolish the present method of control over the medical officers of dispensaries by lay members of the dispensary committee. They are a source of constant friction and annoyance to conscientious medical officers and beyond only paying official visits to enquire into the wants of the dispensary these visiting officers should have no more to do with its internal management, the control of which should be left solely to the civil surgeon of the district.

7. I am of opinion that as in the case of civil hospitals, Indian station hospitals should have at least one officer of the standing of assistant surgeon attached to say 50 or 100 beds who could also take his tour of duty as resident medical officer. The duties of military sub-assistant surgeon would then be that of house surgeon or house physician to senior visiting medical officer as in large civil hospitals. He would be held responsible for the writing of cases, the dressing of surgical cases, writing of prescription books, diet charts, etc., and perhaps one or more of them be detained to take charge of medical stores, to do compounding, to prepare returns, etc. Their number would depend on the strength of the station hospital.

8. So far as the students of the Poona medical school are concerned, the training of both civil and military pupils is practically the same except perhaps the squad drill and the stretcher drill which though taught to both classes of pupils, receive greater attention in the case of military students. No other difference exists in their training either regarding professional or other work. For all other practical purposes there would be no difference found in the work of the sub-assistant surgeons when they are newly entertained, be they civil or military.

10. I have already in a way answered this question in paragraph 7. For large station hospitals at least one officer of the standing of assistant surgeon for every 50 or 100 beds would be not only a great desideratum but a source of help and strength to the senior officer in charge. Such an arrangement would not only be conducive to better attention being given to the patients but to my mind it would indirectly stimulate research and knowledge which 'could only be attained by a greater division of work entrusted to well trained men of superior mental calibre.

11. The sub-assistant surgeon class of service though inferior is a most useful branch of medical service both for civil and military purposes. In recent years their lot has to a certain extent been improved, and their minimum and maximum pay have both been raised but much requires to be done still. I think, to begin with, the standard of entrance to medical schools should be raised from standard VI to the matriculation. Already matriculates and occasionally men of even higher preliminary qualifications enter the school in fair numbers and their number is steadily increasing. The Miraj medical school has also made matriculation the least qualification for entrance to school. I have no doubt if once for all the increased standard of matriculation is made compulsory sufficient candidates would be forthcoming especially if they are assured of an improvement of prospects.

14. So long as the state of training and qualifications of these men remain as at present, I can find no work for them if they are no longer wanted for purely British military hospitals. Their educational and professional qualifications being on a par with that of sub-assistant surgeons would certainly entitle them to all the privileges of the latter, which however they would naturally consider derogatory to their interests. On the other hand their employment in the same capacity as that of civil assistant surgeons would be resented by that class of officer.

15. I am emphatically of that opinion.

16. The qualification registrable in the United Kingdom outside a university degree is that of a membership or fellowship of the college of physicians and surgeons. The conditions necessary to be fulfilled to obtain the latter are identically the same as the former. Both require the preliminary standard of the University P. E., and a full course of five years' training at a recognised medical college. Under the circumstances

20 March 1919.]

Civil Assistant Surgeon E. S. BHARUCHA.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

I would consider it more to his advantage to try and obtain the university qualification. He would thus *ipso facto* be entitled to all the privileges of assistant surgeons. In other words if it is decided (as it should be) to raise his qualification to one registrable in the United Kingdom no difference would then exist between him and the civil assistant surgeon beyond that of race.

17. I would put him on a par with civil assistant surgeon to which he would by right be entitled.

18. Once his qualification is raised as stated above his conditions of service should be the same as that of a civil assistant surgeon.

Questions for civil assistant surgeons.

1. I am now practically at the end of my service but if wanted I am willing to serve with Indian troops and in Indian station hospitals, provided my present prospects do not suffer in any way.

2. No. There is a general feeling amongst members of my service that considering that the civil assistant surgeons enter service mostly at a later period of age owing to the long course of study and considering the arduous nature of their duties which involve heavy strain, and expose them to risk of infection, etc., without holidays including work on Sundays even, our men should be allowed to retire voluntarily on full pension after an approved service of 25 years or on being invalided after 20 years' service.

3. I do not understand the force of this question. It evidently relates to provision for the widows and orphans of military assistant surgeons with which I am not acquainted. So far as the civil assistant surgeons are concerned besides the rules of the General Provident Fund I am not aware of any other kind of provision referred to.

4. (a) The title or designation of civil assistant surgeon by which the class is recognised should be abolished. An assistant surgeon from the day he joins his service to the day he leaves it is dubbed as an assistant even when he serves as a permanent or officiating civil surgeon. This is a grievance which has been unanimously recognised by the Public Services Commission and it is time early steps should be taken to give effect to their recommendation.

(b) The members of the service feel keenly that though they are recruited as gazetted officers, they are treated to all intents and purposes in the matter of leave, transfer, etc., as non-gazetted officers. When I joined service nearly 30 years ago and for about 10 years after, all such notifications used to appear in the body of the gazette under the signature of Secretary to the Government in the General Department. That practice has been since considerably modified. Not only the first appointment and promotions after septennial examinations and the grade of senior assistant surgeons and civil surgeons appear in the gazetted list. All other notifications appear at the end of the gazette in general notifications under the signature of the Surgeon-General. Personally I do not think the procedure in any way affects the appointments as all of them are originally proposed by the Surgeon-General. But I know this fact is used by certain members of others services unaware with the conditions of our service against us, and I have heard of cases of friction on that score having occurred between assistant surgeons and such officers in the taluka towns. I would propose a reversion to the old state of affairs which our men will consider as a great act of justice to them and their prestige.

(c) The members of my service have always solely felt the degradation to which they are put by compelling them to pass the two septennial examinations at the end of a service of seven and fourteen years respectively. It is the latter which they feel most as by the time they have been 14 years in service they have not only grown in age but have been in many cases entirely out of touch with large hospitals and find it difficult to wade through the ponderous volumes of all the important branches of medicine at that period of life.

Instead I would propose a post graduate course and facilities for study leave both in and out of India. Advantage of the latter would be freely taken if suitable openings for bettering their conditions are held out to them.

(d) The civil assistant surgeons have always felt that there are few appointments within their reach to enable them to extend their knowledge or to do any specialised or original work. Beyond the few appointments of teachers of medical schools there are no suitable openings for our men to prove their merit. All the house surgeoncies are reserved for military assistant surgeons. Of the four civil surgeoncies two at least are inferior in point of professional work to first class dispensaries. In fact one of them, *viz.*, Alibag was a second rate dispensary before it was made into a civil surgeoncy. The house surgeoncies held by the military assistant surgeons should be opened for the members of the provincial service and when promoted as civil surgeons they should not be tied to the few particular posts at present reserved for them.

(e) The next disability, if I may be permitted to say so, is the paucity of honours for good services open to civil assistant surgeons. Besides being a Khan Bahadur or a Rao Bahadur an assistant surgeon cannot aspire to any thing else whereas in the case of members of the same grade in the sister services capable men have attained other honours such as Kaisar-i-Hind Medal, Imperial Service Order, etc., not to mention still higher honours to which also some of them have been raised.

5. The best men from the university either go for higher studies in England with a view to qualify for Indian Medical Service or for M. D., F. R. C. S. and other degrees. A good porportion of them settle down in practice as they consider their prospects in service to be very poor. In this connection the following remarks from a paper written by me in 1913, may not be out of place.

"The service is undoubtedly at present not as popular and efficient as it was about 20 years ago. Then mostly first class men were recruited as civil assistant surgeons whereas at present since 1896, out of 40 new appointments only three have passed in the first class. Below is appended a table showing the university careers of assistant surgeons at present in service recruited before and after 1896.

1st No. of Civil Assistant Surgeons recruited before 1896.	University Career		TOTAL
	1st Class.	2nd Class.	
22	18	4	22
2nd No. of Civil Assistant Surgeons recruited after 1896-1913			
40	3	37	40

Since 1913, owing to the great war the condition has become even more pronounced. I have no doubt with the offer of better pay to start with and suitable openings to rise and altering their conditions and prospects radically, a good class of men would be easily found.

6. I think the present method of recruiting should continue but as before as far as possible only first class men or those standing high on the list of newly passed graduates (if 1st class men are not available) should only be entertained. To ensure this I need hardly repeat that the pay and prospects need radical alterations.

7. This would be highly objected to by the whole body of the civil service in the present state of training and qualifications of military assistant surgeons. Unless the latter also belong to the university, civil assistant surgeons would feel aggrieved if more civil appointments were thrown open to them. As it is the three appointments of civil surgeons reserved for the class of military assistant surgeons and practically all the house surgeoncies held by them exclusively is a subject keenly felt and resented by the members of my service. Personally I would say our service would gladly welcome them in the civil department if they come by the open door, *i.e.*, after passing the same test that the civil assistant surgeons do but not till then.

8. Provided the pay and prospects are suitably improved our men would be ready to be amalgamated into an united service and would only feel too proud to do

20 March 1919.]

Civil Assistant Surgeon E. S. BHARUCHA.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

so. Then they would naturally have to go through a course of military training and to respond to calls for military employment in case of war. This has been conclusively demonstrated by the ready response which civil assistant surgeons gave to the call to duty in the present war. 14 out of a permanent cadre of 60 and 21 out of the temporary list voluntarily went on military service during the war. More would have gone but I presume their services could not be spared and the seniors were considered overage.

Question for witnesses.

1. None of the four schemes circulated appears to me to be satisfactory in its entirety. For reasons stated in the attached memorandum I am inclined to accept several of the proposals in scheme A with certain reservations pointed out in it. They are briefly (a) the institution of simultaneous examinations both in England and in India, (b) the reservation of more appointments for Indians in the civil medical department.

3. So far as recruiting from Indian graduates is concerned I am confident of its attracting a good stamp of men. If a simultaneous examination is held both in England and in India only first class men from various colleges will compete. I cannot give any opinion regarding conditions in England.

4. I do not know how the withdrawal of European medical officers from charge of troops has affected them but their substitution by members of the provincial medical service in the civil department has caused little or no inconvenience. Judging from the profuse thanks accorded to all civil surgeons and other medical officers by Surgeon-General Lyons on the eve of his retirement in his last annual report the only conclusion at which one could arrive is that the civil medical work of districts, carried on with "a depleted staff" and "in financial straits," has been an entire success, part if not the whole credit of which is due to the members of the provincial medical service who filled up the gap caused by the surrender of Indian Medical Service civil surgeons.

5. I think it will meet the needs of the civil administration quite efficiently. As to what effects it would have in case of needs occasioned by war on a large scale I have already explained in the memorandum submitted

by me that no kind of war reserve would be of any avail in great emergencies as experienced in the past four years.

6. A sufficient and efficient reserve for military purpose such as the one we have just passed through is in my opinion an impossibility. Reliance must be placed on volunteering from private practitioners. Their numbers should be increased which could only be done by establishing more medical colleges and schools.

7. It would be an advantage to have every medical man trained for military medical work, for which a special course of say three or six months might be arranged in the different schools and colleges.

8. Very little. Roughly about 300 of the 398 Indian Medical Service officers in civil employ were surrendered and yet 800 or more temporary commissions had to be filled up mostly from the private practitioners and members of the provincial medical service. Produce more doctors and not only 500 but double that number will be forthcoming.

9. I have already explained that fully in the statement submitted herewith. For the auxiliary corps I would suggest either simultaneous examination both in England and in India or better still in India only. For the civil medical service Imperial grades simultaneous examinations both in England and India should be arranged and for the provincial and subordinate services as at present.

10. Facilities for study leave should be given to all grades of officers up to a period of three years at least in the whole service. One year's leave could be earned after a continuous period of five years, and it may be allowed to be accumulated if necessary for two such periods. Thus either an officer may take one year at the end of five years' or two years at the end of ten years' service and one year again at the end of 15 years. No such leave could be earned after 15 years. The leave in the case of Imperial officers may be made compulsory to be spent in England, in the case of the other two classes of officers either in England or India.

12. That private practice has declined all round in the case of all Government medical officers is now a well established fact. This is only to be expected considering the increased number of competent local practitioners in all large towns but men who are considered specialists and have an established reputation in my opinion still continue to command a large practice.

Civil Assistant Surgeon BHARUCHA, called and examined.

(Mr. Hignell.) He was in favour of the separation of the civil and military services and with that object he was in favour of scheme A. The auxiliary corps referred to in the scheme, which would be composed of Indians and Anglo-Indians, would to some extent be looked down upon as inferior, and in that respect scheme A was not altogether satisfactory. At present, as the scheme stood, a differentiation was made between the European and Indian. This differentiation would not occur if the Royal Army Medical Corps opened its ranks to Indians.

He had served most of his time in the Bombay Presidency. He had spent nearly 25 years in Poona. At the commencement of his service he had been all over the Presidency. His experience justified his saying that there was plenty of room for expansion in the matter of superior medical relief. Each district should have an assistant to the civil surgeon. He would be very pleased to have two assistants to civil surgeons if this was considered necessary.

He considered it a grievance that civil assistant surgeons were unfairly treated in comparison with military assistant surgeons in the matter of civil surgeoncies. In the Bombay Presidency three civil surgeoncies were reserved for military and four for civil assistant surgeons—a total of seven in all. The civil surgeoncies granted to the military assistant surgeons were superior to two or three of those granted to civil assistant surgeons. In his opinion all the seven civil surgeoncies should be given to the civil assistant surgeons.

(General Hehir.) Since he had written his statement he had heard that the pay of the sub-assistant surgeons had been increased and he thought that the increased rate of pay satisfied them.

The candidates that were entering for civil assistant surgeons were certainly not of the same class that entered 30 years ago. He referred the Committee to his written statement wherein was shown the class of men that entered before and after 1896. All the really good men entered the Indian Medical Service or took up private practice.

(Sir T. Nariman.) He was really in favour of the civil side of the scheme A. The military side of the scheme had drawbacks and for this reason he would only accept the scheme with the modifications suggested by him.

He had been a teacher for 25 years and he could say that Indians were quite capable of taking up professional appointments. He considered it a grievance that after teaching for 25 years he had not been transferred to the Grant Medical College. Indians could do just as well as Europeans in the teaching line.

Out of a total of 60 civil assistant surgeons in the Bombay Presidency 35 volunteered for military duty.

He considered it a grievance that civil assistant surgeons at times had to work under military assistant surgeons, whose qualifications were not registrable.

The simultaneous examinations suggested in his written statement would be taken as one examination.

20 March 1919.]

Civil Assistant Surgeon E. S. BHARUCHA.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

If necessary he would give those that passed in India a further course of six months' training in England after selection.

He would gladly amalgamate with the military assistant surgeons if the latter's qualifications were raised.

He did not think that jails had suffered in any way by the withdrawal of European medical officers. He had not heard of any deterioration in jails from this cause.

The report of the late Surgeon-General with the Government of Bombay showed that the civil medical work of districts had been carried on very well with a depleted staff. There was no great difference in the number of outpatients. The number of operations decreased in 1917.

(Colonel Banatvala.) He had suggested the course of post-graduate training in England after selection as he thought it would be good for the student. This post-graduate course might be taken in any subjects. He would not lay down a definite course.

The drafting of civil sub-assistant surgeons for military duty dislocated to a certain extent the civil medical department. Certain dispensaries had to be closed down and in certain districts the closing down of dispensaries had been a real hardship to the population. It meant that people in whose districts the dispensaries were closed had to go elsewhere for treatment. The death rate had not increased very much by the closing down of these dispensaries. He would like to see the promotion examinations for assistant surgeons done away with. He considered it very hard on assistant surgeons to have to pass septennial examinations.

(General Hendley.) Military assistant surgeons should possess registrable qualifications if they wished to be on the same level as civil assistant surgeons.

It would not be necessary for a military assistant surgeon to have a qualification registrable in England if his education was complete and he held a qualification registrable in India, but at the same time he would not be on par with those whose qualifications were registrable in the United Kingdom.

20 March 1919.]

Dr. K. G. LAHOKARE.

*(The schemes and questions referred to by witnesses are contained in Volume III.)***At Bombay, Thursday, 20th March 1919.****PRESENT:**The Hon'ble Sir VERNEY LOVETT, K.C.S.I., I.C.S. (*President*.)MAJOR-GENERAL P. HEHIR, C.B., C.M.G., C.I.E.,
I.M.S.

MAJOR-GENERAL H. HENDLEY, K.H.S., I.M.S.

MAJOR M. T. CRAMER-ROBERTS, D.S.O., Indian
Army.

S. R. HIGNELL, Esq., C.I.E., I.C.S.

LIEUTENANT-COLONEL A. SHAIRP, C.M.G., Indian
Army.and, as co-opted members SIR T. NARIMAN, Kt., the Hon'ble COLONEL H. E. BANATVALA, C.S.I., I.M.S., and
LIEUTENANT-COLONEL BHOLA NATH, C.I.E., I.M.S.MAJOR A. A. McNEIGHT, I.M.S. (*Secretary*).Dr. K. G. LAHOKARE, B.A., Representative of the All-India Sub-Assistant Surgeons' Association, Bombay
Presidency Branch.*Written statement.**Questions for military and civil sub-assistant surgeons.*

1. The sub-assistant surgeons are not satisfied with their present rank as Indian warrant officers:—

- (a) The rank of Indian warrant officer does not exist in the Indian army and is therefore anomalous in the case of sub-assistant surgeons. It does not command respect and a sub-assistant surgeon finds it difficult to maintain discipline in the hospital.
- (b) The educational qualifications of a sub-assistant surgeon are such as would entitle him for a direct Indian commission according to the principles laid down in Army Regulations India, Vol. II, paragraph 545 and 545 (a).
- (c) To be able to maintain the dignity of the profession to which a sub-assistant surgeon belongs, it is imperatively necessary that he should command confidence and respect of those around him and the invidious distinction in rank affects his professional status adversely under the present circumstances. A sub-assistant surgeon to-day is not a "Dresser" of the East India Company regiments with a meagre preliminary education and a smattering of medical science. He has proved himself capable to do general professional work as a fully qualified medical man, and cannot therefore be continued in this rank without detriment to the dignity of the profession. The idea of a warrant rank must go as antiquated with the introduction of a much higher standard of general and scientific education of the sub-assistant surgeon's class as compared with that, existing in days when the rank was first bestowed years ago. The undersigned knows full well the dissatisfaction prevalent amongst the members of this cadre by being placed as warrant officers and the subsequent treatment accorded to them by reason of this lower rank, resulting in incessant applications for resignations thus keeping the cadre strength always at ebb entailing pecuniary loss to the State involved in training the candidates. This was one of the foremost considerations that stood in the way of the members of the class volunteering during the period of the present war.

2. The present professional training of the sub-assistant surgeons' class makes him almost a fully equipped

general practitioner. Many members of the class have evinced a keen desire to further their knowledge. Members working in institutions requiring knowledge in special subjects have proved themselves efficient after a course only as extended as in the case of other medical men. An impetus in the form of study leave would surely make them useful in the branches of their selection. Facilities to attend special courses have been now and then demanded by the resolutions of the various branches of the All-India Sub-Assistant Surgeons' Association. Training in special institutions in the United Kingdom will also be availed of by some members of the class if opportunities were offered. The question whether the sub-assistant surgeons should receive this training in the existing medical colleges or in the proposed new military medical college depends largely on the nature of advantages offered and should be left to their choice. Members desirous of raising their diploma qualifications should find an opportunity here and should have a scope for furthering their prospects. This scheme would also prove useful in the interest of the service.

3. Military sub-assistant surgeons will be much pleased if civil appointments were thrown open to them and the number of the sub-assistant surgeons getting invalidated will be lessened saving thereby some expenditure on training and recruitment in either of the branches civil or military. But the civil sub-assistant surgeons will feel themselves aggrieved by the arrangement. If military sub-assistant surgeons are drafted to civil duties to serve as reserve strength, the civil department will suffer considerably when this reserve is drawn upon. If this arrangement is an attempt to keep the military cadre strength full, the undersigned thinks that a substantial practice allowance to military sub-assistant surgeons over and above the civil scale will serve the purpose. This will keep the military sub-assistant surgeons contented and the strength will not much fall off. A retainer allowance may perhaps be useful in securing services of some in times of emergency. A combined list for fresh recruitment on the lines of the one existing some 30 years before, just as in the case of Indian Medical Service officers is worth consideration provided the members are allowed a substantial allowance in lieu of private practice when in military service.

4. Pupils seeking admission to the sub-assistant surgeons' class should have the same standard of preliminary education as is required by the General Medical Council of the United Kingdom. The school-leaving

20 March 1919.]

Dr. K. G. LAHOKARE.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

certificate or the matriculation examination should be the condition for admission and this should be supplemented by an entrance examination at each medical school so as to cover any subjects falling short of the standard required by the General Medical Council. This will not affect recruitment since many of the pupils seeking admission to each medical school in these days are found to be matriculates.

5. A number of pupils seeking admission into the medical schools are generally from families whose means do not allow any expenditure on higher education. Many an intelligent lad seeks admission into the medical school simply because he is supported by the State while he is being trained. A money deposit security is in almost all cases an impossibility. The present system of a personal security bond is a sufficient guarantee of the pupil continuing the course and completing the necessary five years' service. A regular money deposit being a real difficulty with the class of pupils undertaking this course, recruitment will be materially affected if it is introduced. Present public opinion favours collegiate education in Arts and if money is available for fees and books even a matriculated pupil would prefer taking that course rather than the medical school course. A personal security bond alone should be considered sufficient as long as this branch of service is not considered attractive.

6. The bond signed by civil sub-assistant surgeons may have the clause of military service within a period of the first five years. A special war reserve should be created by paying the civil sub-assistant surgeons a retaining fee after completion of the first five years' service. Liberal war allowances would induce voluntary admission into military service in sufficient numbers.

7. Service with the army under present conditions is far from satisfactory to civil sub-assistant surgeons. Reasons are as follow :—

- (a) They consider their status in the military department humiliating as compared to the one they hold while in civil employ.
- (b) The nature of work they have to do, they consider ignoble, because their medical skill they have scarcely to put to use. They are only a combination of a clerk, a dresser, a compounder and a male nurse. They have practically nothing to do which is expected of a qualified medical man.

Remedies for making the service acceptable are :—

- (a) They should have a recognised status in the army at least that of an Indian commissioned officer to begin with.
- (b) They should have more of scientific work to do than that of a clerk, compounder, dresser, etc. Separate men should be employed for the purposes of clerical work, compounding and dressing which can easily be done either by regimental clerks or by trained ward orderlies.
- (c) Military service allowance should cover the highest scale of practice earned by a sub-assistant surgeon while in civil employ.

8. To be consistent with the idea of being drafted to military service during the first five years as required by the bond to be signed by civil pupils trained at State expense, the civil sub-assistant surgeons may be put to military training for a short term immediately on admission into the service. But the majority of them are of opinion that it should be made compulsory only for those who form the reserve cadre by receiving a retaining fee. Military training as part of medical school curriculum may become unpopular and affect recruiting; but a short term course, after the professional training is completed, in the first year of service, may not so affect.

9. Both the civil and military sub-assistant surgeons are not satisfied with their present scale of pensions. The civil sub-assistant surgeons think that the worry caused by strenuous work in fairs, famine, epidemic and jail duties has no parallel in the other subordinate services of the Government; while the scale of pensions is

the same for all. They consider justice would be done to them if each year of service under the above heads is counted as two for pension.

Secondly they consider that as work in the medical department knows no time limit and no holidays it entails a heavy strain on them, which hastens a decay of their energy. They therefore wish an ordinary pension after 25 years' service and full invalid pension on completion of 20 years. Invalid pensions should be arranged accordingly. A special scale of pension and provision on the lines of that given to the families of military sub-assistant surgeons killed in action should be introduced for sub-assistant surgeons dying of an epidemic disease while on epidemic duty.

The military sub-assistant surgeons desire a similar change.

The present scale of family pension granted to the widows of military sub-assistant surgeons is to say the least of it not even a pittance. His family should have the same claims as those of an Indian commissioned officer. Considering the necessity of providing for the education of the children and maintenance of the family, the scale of pension allotted to the widows of commissioned officers would be just sufficient for the sub-assistant surgeons' family. In short their demand is that the family pension should be nearly equal to half the pay of the grade at the time of death, while wound and injury pensions should be three-fourths of the pay of the grade at the time of retirement.

10. Such a scheme is quite essential for military sub-assistant surgeons as the benefits of the Postal Life Insurance are not open to them. It should be made compulsory with a provision that the amount should not lapse for want of direct relations but should pass on to his legal heirs.

11. There is a long list of grievances under which the members of the class have been labouring, the following are some of them :—

- (a) Pay.—The civil and military scale of pay should be the same; the military members should receive a substantial allowance in lieu of private practice which is available to the civil members. The following scale of pay is one suggested by the association :—

	Rs.
Fourth grade one to five years' service .	50
Third grade five to ten years' service .	75
Second grade ten to fifteen years' service	110
First grade fifteen to twenty years' service .	150
Senior grade after twenty-two years' service 10 per cent.	200

The military sub-assistant surgeons should receive Rs. 30 for the first ten years of service and Rs. 50 thereafter in addition to the above scale of pay as private practice allowance.

- (b) Promotion to higher rank in the department.—

The sub-assistant surgeons' class differs entirely from every other department of Government service in this respect. A sub-assistant surgeon is a sub-assistant surgeon for ever. No amount of ability, tact and professional skill have ever a chance of being rewarded by a lift here. Military assistant surgeons can have charge of a district even though the standard of education of the class is the same as that of a sub-assistant surgeon. A subordinate of any other department can rise within a shorter period to not only the upper subordinate service but in cases even to the provincial service as well. Different provincial Governments have from time to time recommended removal of this bar to the uplift of the sub-assistant surgeon. It is particularly necessary that a free scope should be given to sub-assistant surgeons to enable them to enter higher ranks in service.

20 March 1919.]

Dr. K. G. LAHOKARE.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

This is possible only by making the preliminary standard of education for admission to the sub-assistant surgeons' class the same as that required by the Medical Council of the United Kingdom. Secondly, the syllabus of the subjects prescribed for the class should be the same as prescribed by the General Medical Council, so that the sub-assistant surgeon would be able to take a higher qualification diploma simply by attending courses in subjects left out of the course here.

I would further suggest that there should be a competitive examination for filling in the assistant surgeons' posts in each province, and sub-assistant surgeons should be allowed to compete. This would encourage intelligent men to take up the medical school course and would popularise the service as well.

- (c) *Designation.*—In military service the designation should be military assistant surgeons. The Indian army possesses no such class. The designations of the civil medical service be laid down as under.

District medical officer for civil surgeons.
Assistant medical officer for assistant surgeon.

Deputy medical officer for sub-assistant surgeon.

In the alternative the term deputy surgeon be substituted for "sub-assistant surgeon."

- (d) *Representation on the medical councils.*

The present representation of provincial councils is very meagre; it should be adequate compared to their number.

- (e) *Travelling allowances.*—Military sub-assistant surgeons have been demanding travelling on E Form as it was before 1905. Civil sub-assistant surgeons request revision of the rules since frequent transfers cost their pockets more than what they are given. Mileage should be raised to 4 annas a mile.

- (f) *Jail duty.*—The hardship involved by being under jail discipline and by losing private practice should be better rewarded. Rs. 30 for the last two grades and Rs. 50 for the higher grades should be the minimum allowance. Sub-assistant surgeons should not be subordinate to non-medical jail authorities.

- (g) *Subordination to other authorities.*—Sub-assistant surgeons are very unwilling to serve under non-medical authorities such as the dispensary committees of the municipalities and local boards.

- (h) *Compensation in lieu of quarters.*—In every town rents have enormously increased of late. Double the former rates is the least requirement.

- (i) The military sub-assistant surgeons should be paid an allowance of Rs. 5 per mensem for

the upkeep of uniform, etc., they should be given a sum of Rs. 200 as kit-money to begin with.

- (j) *Higher ranks in military.*—Military sub-assistant surgeons should be rewarded with honorary British commissions at least in cases of long and meritorious service.

12. The present method of pupils being trained at State expense is the only way of getting men to undertake the training under the present circumstances. The number and amount of stipends in each medical school should be raised and should be uniform for both the civil and military. The sub-assistant surgeons' service not being yet attractive, time has not yet arrived when the inducement of stipends can be done away with. Medical schools in different provinces should be continued as heretofore; but they should be better equipped, well staffed and should have a uniform standardised curriculum throughout.

13. (a) The warrant rank does not exist in the Indian army and is not understood by the rank and file. A star on the fore-arm is misunderstood as a substitute for ribbon. It therefore goes difficult for a sub-assistant surgeon to get himself obeyed.

(b) The Indian commissioned officers of regiments are in virtue of the warrant rank of the sub-assistant surgeon superior to him and being uneducated become a source of interference in many cases, the more so since they serve as visiting officers of the hospitals. Equality of rank would remove the trouble.

(c) Patients and servants of the hospital belong to the regiments or are drawn from the rank and file. They are intimately connected with the Indian commissioned officers, and it goes difficult for the sub-assistant surgeons to control these men for fear of displeasure of the commissioned officers whose subordinates the sub-assistant surgeons are in effect. Equality in rank is the remedy prayed for by the class.

14. They will not be much affected if military service is voluntary on the reserve strength basis, provided they are placed in the Indian commissioned rank.

15. Service as a military sub-assistant surgeon is very unpopular on account of the inferior position he holds and the amount of non-professional work he has to do in the army. The undersigned has seen that at the entrance examination of a medical school many boys—especially of better calibre (matriculates and under-graduates)—refuse military stipends even when they cannot get civil ones. Unless the military service is rendered more attractive, the condition at the time of recruitment of compulsory field service in time of war is sure to tell heavily on recruitment of civil sub-assistant surgeons. The remedy lies in improving the military rank and pay with practice allowance and entrusting the sub-assistant surgeon with real professional work instead of utilising him for inferior type of work such as of compounder, dresser, clerk, etc. If these improvements are effected there seems to be no reason why the recruitments should be so disappointing.

DR. LAHOKARE, called and examined.

(General Hehir.) He took his B.A. degree in the year 1908, five years after he had qualified as a sub-assistant surgeon. Only very few students who had had a training in an arts college joined the medical schools.

He began his life as a sub-assistant surgeon and had also served in the military department. He thought that the proposals which he had submitted in his written statement were all practical propositions.

In recent years, a great many concessions had been shewn to sub-assistant surgeons, but they were not

in any way commensurate with the standard of education which sub-assistant surgeons had received.

They desired to become qualified medical men. They did not go to the assistant surgeon class because of the scarcity of schools and colleges and also because of the expenditure involved in undergoing the full course of training for civil assistant surgeons.

They should be given every facility to improve their education. If their education was improved, the country as a whole would be benefited. Government

20 March 1919.]

Dr. K. G. LAHOKARE.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

should not content themselves with the mere fact that sub-assistant surgeons were doing satisfactorily the work for which they were intended. If Government were not prepared to take a broader view of the question, it would, in his opinion, be better to abolish the present sub-assistant surgeon class and establish in its place another which would meet only the requirements of Government.

In his written statement he had suggested that military sub-assistant surgeons should be given some allowance as a compensation for private practice, because they did not stand any chance of being transferred to civil and having some private practice. He would not advocate any such allowance for Indian Medical Service officers in military employ, because they were always likely to be transferred to civil later.

A civil sub-assistant surgeon in charge of a dispensary in a taluk had the status of an officer, whereas his contemporary in military employ had no such status. The duties of military sub-assistant surgeons were more of the nature of clerical and compounding work than of scientific and professional work.

He thought that many of the grievances of military sub-assistant surgeons would be removed if they were only engaged as house surgeons or house physicians, and if much of the routine work were done by compounders and others specially appointed for the purpose.

Sub-assistant surgeons might not be fit to receive commissions directly they passed out of a medical school; but if they were given a military training, they would be fit. He insisted that such a training should be given in the first year of their service.

The military service allowance which he had recommended in his written statement, to be given to those sub-assistant surgeons drafted from civil to military, should cover the highest private practice earned by them during their civil employ. If the allowance granted them did not cover their private practice, they would not volunteer; and, if they were drafted to military duty under compulsion, they would always think that they had been badly treated by Government and discontent would be the result.

If Government ceased to give stipends to sub-assistant surgeons, he had no doubt that there would be a falling off in recruiting.

DR. N. H. CHOKSY, M.D., KHAN BAHADUR, Representative of the Bombay Medical Union.

Written statement.

1. The consideration of any scheme for a unified medical service for India has to be approached from a number of standpoints, that are so inter-dependent, that undue regard for, or importance attached to, any one of them, would seriously militate against its success, however, well it may be devised. The requirements of such a scheme could be thus stated:—

- (a) The medical needs of British and Indian troops in time of peace.
- (b) An adequate reserve for war purposes.
- (c) The approval of the War Office, the Secretary of State for India and the Imperial and local governments.
- (d) A satisfactory arrangement for securing the legitimate demands and aspirations of the Indian profession.
- (e) The pronouncement of the Secretary of State for India of 20th August 1917.
- (f) The gradual increment of the Indian element in all services hitherto entirely recruited in England, commencing at 33 per cent. and increasing yearly by 15 per cent. up to 10 to 12 years. (*Vide* Report on Constitutional Reforms in India by Mr. Montagu and His Excellency the Viceroy.)
- (g) The Secretary of State's reply to the representation of the deputation from the British Medical Association.—“That the Indian Medical Service must afford in its organisation increased and increasing opportunities for Indians to enter the service. I am sure, you will admit, that this is essential if the service is to continue to be firmly established in the respect of the people of India. It is in harmony with the policy of His Majesty's Government as regards all services as expressed by them, through me, on August 20th last. The application of this principle means that Indians must be trained either in this country, or—I hope increasingly—by improvement and extension of the opportunities for Medical education in India, to enter the service on equal conditions and with equal opportunities of promotion. This

involves, among other things, the development of aided schools and colleges in India. I need hardly say, but I ought to say, that the assertion of this principle is not intended to detract from the necessity of keeping an adequate proportion of officers from Home, both to supply the needs of the European service and to maintain the traditions of the service.” (*Vide*, British Medical Journal, Supplement, July 6th 1918.)

- (h) A due consideration of the claims of over 800 officers at present holding temporary commissions in the Indian Medical Service with regard to whom the Secretary of State expressed himself thus*:—“At the same time it must be obvious that a man's record of temporary service, rendered under the exacting conditions of war will be a most valuable criterion of the qualities of initiative, self-reliance and pluck which are so necessary in the case of a service like the one we are now discussing.” (*Vide* *ibid.*)
- (i) The civil medical requirements of India; the provision of consultants and specialists, the staffing of educational, sanitary, bacteriological and other departments.
- (j) The public health needs of India, and the creation of a village and district sanitary service.
- (k) Medical research and investigation of tropical diseases.

2. The careful study of the schemes A, B, C and D indicates that sufficient importance has not been directed to all the above factors. Whilst some have been entirely overlooked, others have been considered from the point of view of the existing services alone, without due regard to the ultimate results to the interests of India. What is required at present is a broad, generous and statesmenlike policy fully appreciating the possibilities of the immediate future and not a strict adherence to the one or the other existing department of public service. Something more than mere departmental or service considerations is involved in the present inquiry, and consequently a thorough grasp of

* In reference to the suggestion of the deputation that the grant of temporary commissions should carry with it no guarantee of subsequent permanent appointments, the Secretary of State stated that such was the case, and that there existed a clause to the effect in their agreement and proceeded to add

20 March 1919.]

Dr. N. H. CHOKSY.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

the future of the services themselves, not less than of the whole Indian profession is essential. Whilst not denying the necessity of safe-guarding the privileges and claims of existing interests, care should be taken in devising any scheme that the continuance of the older system, for a period longer than absolutely necessary for its proper adjustment to the new conditions, would not eventually perpetuate the very anomalies that are intended to be remedied by this Committee. I venture therefore to submit for the consideration of the Committee the following scheme which would go to some extent to satisfy the requirements above laid down.

3. A really unified state medical service for India would mean the complete, but periodical, fusion of the two existing services:—Royal Army Medical Corps and Indian Medical Service. Such fusion having been found to be impracticable, various devices have been suggested to leaven one or the other service with transfers or seconding according to the personal inclinations of the framers of the schemes. At the best, this is but a poor makeshift and demonstrates the futility of unification, where the conditions of the services are so diverse and to all intents and purposes not interchangeable. And I submit that the only justification for such transfers or secondings would be a grave necessity requiring the infusion of new blood, into a decadent or inefficient service, which neither the Royal Army Medical Corps nor the Indian Medical Service, could be said to be. Consequently, schemes on paper, however attractive, would fail to secure a lasting element of success. I have therefore submitted a scheme which whilst drawing upon some points from the schemes suggested, has taken full cognisance of the data laid down in paragraph 1.

4. I therefore suggest that there should be two main divisions of the services in India, *viz.*, a military medical service and a civil medical service.

A.—Military medical service.

5. (i) *Name*.—Indian military medical service or Indian army medical corps.

(ii) *Recruitment*.—(a) By open competitive examination held simultaneously in England and India and to be open to all British born subjects as hitherto. (b) In case this is shown to be totally impracticable for special reasons, such as the requirements of practical examinations and need of professional and social training—by open competition in England alone. (c) The Government of India should, in the latter event, create a sufficient number of scholarships tenable in England for Indian candidates desirous of competing for the service so as to allow of the entry of a fixed proportion of Indians, who would compete on *equal conditions* as laid down by the Secretary of State for India. The scholarships to be conferred on the recommendation of the several universities in India. These scholarships should not debar other Indians from competing. At the same time, the Government of India should make an effort to raise the standard of medical education in India to such a level as to obviate the necessity of completing professional training in Great Britain as suggested by the Secretary of State. (d) If unification of some sort is considered absolutely necessary, recruitment from the Royal Army Medical Corps. Considering, however, that Indians are not allowed to enter this service, unlimited transfers or secondings would virtually mean the exclusion of Indians from the military branch of the service. Therefore it is suggested that the number of Royal Army Medical Corps officers in the Indian army medical corps should bear to the total strength of that corps the same ratio that the British army in India bear to the total standing army of India.

(iii) The Indian army medical corps to constitute a purely military service and candidates entering the

same should be told that this service confers no right to civil appointments or private practice in India. The cadre on peace strength to be at rate of 4 per mille for British troops and 3 per mille for Indian troops.

(iv) *Standard*.—The present standard of examinations as for the Indian Medical Service should be retained. In the case of Indian candidates no invidious distinction should be created between Indian and British qualifications, so long as they possess qualifications recognised by the General Medical Council of Great Britain for registration in the colonial list. Indian candidates without British qualifications should not therefore be debarred from competing.

(v) *War-reserve*.—The war reserve to be constituted from (a) the whole of the civil medical service—the professorial or educational posts excepted; (b) from the civil assistant surgeons. The members of both these services to give an undertaking on joining to perform military duty when called upon during war; (c) by the creation of a special reserve medical corps from the independent medical profession. The above should have regular and periodic training in military medicine, surgery, sanitation administration, law, regulations, discipline, etc., at an Indian army medical college to be established for the purpose in a central locality. After preliminary training in these branches, special courses of instruction should be instituted and so arranged as to create the minimum of disturbance to their regular duties or to their practice. Those in the special reserve should be paid a retaining fee or bonus. All officers undergoing military training to have temporary army rank corresponding to their status in the service or profession.

(vi) *Station hospitals*.—The station hospitals for British and Indian troops should be separate in order to avoid friction and inter-service jealousies. Each hospital to be administered by its own unit of Royal Army Medical Corps or Indian Medical Service. There should be no distinctions of pay and allowance between the two services; as also between the nursing staff and European and Indian personnel performing identical duties.

(vii) *Indian Army Medical Corps*.—(a) The subordinate personnel of this service to be amalgamated with it, as is the case in the Royal Army Medical Corps with warrant officers, and orderlies and other staff.

But the existing anomaly of a special service of warrant officers, created specially to serve with British troops in India, *viz.*—the military assistant surgeons, requires adjustment, if not total abolition. This department is non-existent in British Home and Colonial Service; and the Royal Army Medical Corps personnel perform all the work without such an agency. What justification there exists for this class of men in the Indian branch of the Royal Army Medical Corps is not known.*

This service has been kept as a close preserve for Anglo-Indians and others. And it has received favoured treatment in rank, status, emoluments and honorary commissions, from which Indians have been not only rigorously excluded, but Indians doing the same work, *viz.*, military sub-assistant surgeons, having the same training, the same qualifications, have been most invidiously treated in this regard, thus creating heart-burning and dissatisfaction owing to racial discrimination. Not only do the military sub-assistant surgeons—all Indians—have to put up with the indignity of being considered their inferiors, but situations often arise where these military assistant surgeons have been given positions, above university graduates possessing higher general and professional qualifications, who have been placed under them at lower salaries.

Nothing could better illustrate this invidious treatment of Indians than the sub-joined statement comparing the status and emoluments of the two classes:—

* It appears that this department owes its existence to a school for the orphans of British soldiers at Calcutta. As no suitable work could be found for the boys, they were sent to a hospital to learn dressers' work and were called "Hospital Mates."

20 March 1919.]

Dr. N. H. CHOKSY.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

*Table showing the qualifications and salaries of (a) military assistant surgeons, (b) sub-assistant surgeons (military).

	INDIANS.	ANGLO-INDIANS.
Standard for entrance	V or VI Standard	Syllabus of Examination shows V Standard studies.
Training	Four years	Four years.
Qualification . . .	L. C. P. & S. (Bombay) General Department Order No. 4767 of 11th July 1917.	L. C. P. & S. (Bombay).
Title	Sub-Assistant Surgeons.	Assistant Surgeons.
Pay (on Military Service)—		
4th grade	None	100
3rd "	60	150
2nd "	75	200
1st "	95	250
Senior—		
2nd "	110	250 Hon. Lieut.
1st "	125	350 " Capt.
Promotion	Into the grade of Assistant Surgeons maximum pay Rs. 250. So far only one promoted.	Into the grade of Civil Surgeons (i.e., posts listed for the I. M. S.) having Assistant Surgeons (university graduates with six years' training) under them. Maximum pay Rs. 850. Promotion after 15 years' service.

They had the rank and pay of soldiers; that was in 1812. About 1832 some of the boys who were found suitable after a hospital course of two years,—were sent to a medical school and were subsequently drafted into British army hospitals and styled "Apothecaries." In 1853, their course of medical training was increased to three years and they were given the rank of warrant officers. And in 1893, the course of study was extended to four years. The East India Company largely utilised their services, in the Indian Marine. This enabled some of the men to avail themselves of long furloughs, to prosecute their studies in Great Britain, to obtain British qualifications and to enter the Indian Medical Service which they did in some numbers up to 1880. The origin of the service was therefore the need of providing work for the orphans of British troops, and not actual military exigencies. Beginning as "Hospital Mates," they advanced to be "Apothecaries," and subsequently "Military Assistant Surgeons" and holders of honorary commissions in the British army and also as civil, medical and railway officers, etc., and other similar posts which should have legitimately belonged to the Indian university graduates.

I would, therefore, suggest the gradual reduction in the cadre of this department until it ceases to exist. In the event of the Committee finding itself unable to recommend its abolition, it should be limited to strictly military duties and be debarred from all civil work in conformity with the rules affecting the officers of the Indian army medical corps.

(v) *Military sub-assistant surgeons.*—They should continue to serve in military capacity in peace and war as hitherto, but the disparity between them and the military assistant surgeons should be removed. They should have the rank of warrant officers but if inadmissible in the case of the Indian army, Indian commissions should be given to them to ensure to them

the respect that is due to them as subordinate medical officers.

Until such time as the class of military assistant surgeons continues to exist, their standard as also that of military sub-assistant surgeons should be raised; but there is no possibility of fusion, smooth working and absence of jealousy owing to racial discrimination so long as both the classes do not possess a qualification at least equal to the old L. M. and S. or other, enabling them to registration by the General Medical Council. In process of time, the present inequalities in preliminary and professional training would thus disappear, and eventually one uniform profession would be evolved as in Great Britain.

B.—Civil medical service.

6. (i) Name.—Indian civil medical service.

(ii) *Recruitment.*—As for Indian army medical corps (*Vide* 5 A (ii) (a), (b), (c), *supra*) except for professorial appointments and specialist posts. (d) By permanent transfers from the Indian army medical corps on account of special qualifications, and research work. They should not be under eight years and over ten, in military service, and on appointment should cease to belong to the army. They should be selected by a Selection Board appointed (*vide infra*) by the Government of India. Such transfers should not exceed 5 per cent. of the cadre of the Indian civil medical service.

(iii) *Standard.*—Same as above for the Indian army medical corps (*vide supra*, 5 A (IV)).

(iv) *Duties.*—All civil surgeonships, jails, lunatic asylums, the sanitary and bacteriological posts—all the work, that is at present being done by the civil branch of the Indian Medical Service; special qualifications, and post-graduate work should be required for sanitary, bacteriological, prison and alienist posts.

(v) *War reserve.*—The Indian civil medical service, etc. (*vide* 5 A (V)).

(vi) *Professorial or educational appointments.*—All professorial appointments in the existing medical colleges and in those to be hereafter established should be thrown open to the profession at large in the United Kingdom and India. Members of the Royal Army Medical Corps, Indian army medical corps, Indian civil medical service should be eligible. Only those who have done approved original or research work in their special branch to be appointed. They should be full time officers, devoting all their time to their duties. They should be debarred from all private and general consulting practice. Special consulting practice in the officers' special branch may be allowed, with restrictions as to their number, and the time occupied in order not to prejudicially affect the teaching work. Their salaries should be high by way of compensation for this, and they should rise in a graded scale to the maximum grade according to length of service. They should be excluded from the war reserve.

(vii) *Specialists and consultants.*—To be appointed as above.

(viii) *Selection Board.*—Appointments as per 6 B (vi) *supra*, as also for (vii) should be made by a specially constituted Selection Board under the Government of India; a Selection Board may be created in London, who should submit their selections to the Government of India, with whom alone the appointments should rest. The Selection Board should consist of 5-6 members, at least three of whom should be Indians and the rest members of the Indian civil medical service with the Minister of Education as President.

* Civil sub-assistant surgeon's scale of salary was up to recently as follows:—

	Rs.		Rs.
4th grade	30	Now raised to . . .	50
3rd "	45	Do. . . .	65
2nd "	55	Do. . . .	80
1st "	65	Do. . . .	95
Senior { "	80	Do. . . .	110
"	100	Do. . . .	120

In Bengal, Madras, Bombay (from 1919-20) and Central Provinces.

21 March 1919.]

Dr. N. H. CHOKSY.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

Civil assistant surgeons.

7. This branch of the public medical service consisting of university graduates, should be recruited from the same class except as hereafter recommended. Their university status, and college career should be given due weight and they should be appointed by a Provincial Selection Board, constituted of four members, with one Indian Minister or Member of the Executive Council as President. Their pay and status require increase considering that they discharge responsible duties in dispensaries and hospitals. Their present scale of pay, reaching to Rs. 350 after 21 years' service is quite inadequate. It is true, that recently a few civil surgeoncies have been allotted to them in each province, but as a rule they are remote and uncongenial posts, varying from Rs. 400-600. These are generally conferred so late in life, that officers cannot put in their full period qualifying them to draw their pensions at higher rates, and as they are very near their time of retirement, such promotions have to be refused.

In view of the increasing sanitary requirements of the country and the difficulty and expense of securing men with British sanitary qualifications, Government should largely expand this branch of the service and hold out special inducements of study periods, to enable them to obtain the degree of Bachelor of Hygiene. With this addition to their attainments, they should be largely incorporated into the sanitary service so as to promote sanitation in towns and villages. Thus equipped and with the help of civil sub-assistant surgeons, they should ultimately constitute the backbone of an universal village and township sanitary service. Being mostly Indians they would be more easily accessible and acceptable to the masses on account of their familiarity with their languages, customs and prejudices. Civil assistant surgeons under 10 years' service showing special aptitude and good work may be promoted into the Indian civil medical service by selection by the Selection Board. And lastly they should be saved from the indignity of having to work under military assistant surgeons, whose preliminary and professional training and attainments are so obviously inferior to theirs.

8. *Civil sub-assistant surgeons.*—The disabilities of the military branch of this service have been dealt with under 5 A (vii) *supra*. Although here the conflict of interests between the two sections is not so acute, it is felt as a grievance that military assistant surgeons should absorb such a large share of civil posts 264 to 475 military whereas the military sub-assistant surgeons have but 123 civil to 648 military. The latter are minor ones, whereas in the former case the salaries may range between Rs. 400 to Rs. 850. Thus it appears, that the military assistant surgeons are again a favoured class and posts that should legitimately go to university men, are absorbed by their cadre.

The same arguments as above are applicable to this class of officers for the improvement of their education and status. They too should form a valuable war reserve after proper training.

9. *Study periods.*—I firmly hold that with the rapid advance in knowledge, newer researches and more exact and improved methods of diagnosis and treatment, no officer who does not periodically refresh his knowledge could remain abreast of the times. This is applicable to all grades of service, military and civil, superior or subordinate. In every grade therefore Government should provide facilities for periodical, revision and post-graduate studies, as also for research in special cases, in Europe and America for the superior services and in India for the lower grades. Without such periodical revision, stagnation and deterioration must ensue, and react ultimately upon the prestige and *esprit de corps* of the services involved.

10. *Conclusion.*—The above sketch is but an attempt to solve a most intricate problem concerned with the

health and well-being of the army in India, in peace and during war, as also of the peoples of India. It lays no claim to completeness or finality. It simply suggests the broad lines along which the services could be reorganised, with due regard to the altered conditions and circumstances of India, both on account of the war and of the impending reforms now under consideration. I sincerely hope that the outcome of the deliberations of this Committee would be such a solution of the question as to satisfy all requirements, military and civil, and, once for all, settle the lines along which the legitimate claims and aspirations of the Indian profession would be met.

Answers to questions for witnesses.

1. None of the schemes A, B, C or D commends itself to me.

2. The scheme which I have submitted will attract a good stamp of recruits and meet the demands of fairminded and unbiassed professional opinion in England and India. I do not anticipate that the scheme that I have proposed has elements of failure, provided it is worked without bias, without fear or favour, without discrimination of race, colour or creed, without undue regard for vested interests, but with the single object of doing the best for the interests of the country.

3. The scheme that I recommend will fully meet with all the requirements of civil administration in India. It will not be adversely affected by a war on a large scale as ample provision has been made for reserves. The experience of the last great war has fully demonstrated that the places left vacant by the commissioned ranks were filled with credit to themselves, and satisfaction to Government by the members of the independent profession within or without the services.

4. I have already dealt with the systems of recruitment and education of medical officers.

5. I have given my views in the penultimate paragraph of my scheme.

6. I entirely associate myself with the remarks of the Director-General at the present sessions of the Imperial Legislative Council as to the absolute and pressing need of a Research Institute and Department, self-contained, unconnected with any branch of medical service, staffed by men of eminence, European and Indian, assisted by Indians of special aptitude. Institutes like these would uplift the prestige of the profession and raise India and its medical men in the estimation of the scientific world.

General considerations regarding organisation of Medical Services.

On perusal of schemes A, B, C, and D, I think that the Committee is much more dealing with the question of how to meet the demands on the service adequately in times of emergency. To meet the demand, supply is the remedy; and the following are the general suggestions for increasing it. (The question of the Imperial services I need not dwell upon.)

To extend the benefits of the western medical science to the doors of the dumb masses in villages, I would suggest a system of grant-in-aid allowances to medical men to supplement their meagre income by resorting to villages to those who agree to do so. This would increase the supply of medical men which can be made available as reserves at any time of emergency either in the civil or in the military.

2. As regards making the sub-assistant surgeons available for military duty in time of emergency, earnest attention is invited to the following as the only means to induce recruitment:—

(a) Increase of the turn-out by increasing the number of medical schools, and by making arrangements to provide for larger numbers in each of them.

(b) Standardising the curriculum in medical schools with a syllabus as required by the

21 March 1919.]

Dr. N. H. CHOKSY.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

General Medical Council of the United Kingdom, in subjects prescribed for the sub-assistant surgeon class. Many more pupils will be attracted to the schools if they find opportunities of raising themselves by an additional course.

- (c) Giving a substantial increase in the rates of pay.
- (d) Giving Indian commissioned rank to begin with and honorary British commissions later on.
- (e) All appointments to the provincial civil service be made by an open competitive examination at which sub-assistant surgeons should be allowed to appear.

(f) Posts of military assistant surgeons should be filled in as in (e). If it is to be a close reserve with no distinctive educational qualifications as at present, they should not be placed over the heads of others since it means a far junior man of the same qualifications above other seniors in service. This is making the military service extremely irritating.

Finally removal of all impediments to a sub-assistant surgeon's attaining either higher qualifications or grades in service is the only remedy to encourage recruitment and it will always result in a large supply of the members of the class being available at any time.

Dr. CHOKSY, called and examined.

(President.) He was a representative of the Bombay Medical Union. The members of that Union were all independent Indian medical practitioners. He had been practising in Bombay for the last 35 years. He had taken the degree of L. M. & S. of the Bombay University and started private practice. After two years, he took up an appointment under the Municipality, and he was working under the same Municipality for the last 32 years as a special 'Assistant Health Officer in charge of the infectious diseases' hospital in Bombay. At the same time he had been doing consulting practice.

The order of Chevalier of the Crown of Italy was conferred upon him in recognition of the services which he had rendered to the Italian Commission when it came to India to study plague, and also in view of his research work in connection with plague.

For the last six years plague had been rather low in Bombay, but previous to that there used to be several thousands cases a year. He thought that it was due more to the immunity of the rats. There had also been a great improvement in the city lately in the matter of laying out streets and in opening up crowded parts. But the customs and habits of the people remained the same whether they lived in palaces or hovels.

The total strength of the Union was about 190. Some of its members had been practising in Bombay, some up-country and some in Europe. All of them practised the western system of medicine.

He thought that there should be two separate medical services, namely, civil and medical. The recruits for the civil should undergo a military training at the beginning of their career and also periodically thereafter. In the beginning, it would suffice if they had a six months' training. The civil medical service should form a war reserve. A certain proportion of the civil medical service should be reserved for promoted civil assistant surgeons.

(General Hehir.) At present the position of military sub-assistant surgeons was very low. They should be given Indian commissions. He did not mean, however, that they should be given commissions immediately after they had left the school, but only after they had undergone a military training.

The Selection Board which he had suggested for the civil medical service should consist of a Member of Council or an Indian Minister, the Surgeon-General and one or two members of the civil medical service. The Member of Council or the Indian Minister should be President of the Selection Board.

(Sir T. Nariman.) Simultaneous examinations should be held in England and in India. If practical examinations should be arranged for the Indian Civil Service, he did not see why they should not be possible in the case of the medical service. One or two of the examiners appointed in England could

come out to India to examine Indian students in practical subjects.

Professors and research scholars should not be allowed private practice. They might be allowed consulting practice; but there should be a limit as to the number of consultations which they could do per month or per day. If the professors spent about five hours a day in consulting practice, they could hardly be expected to do their work satisfactorily.

He did not think that all independent Indian medical practitioners were fit to take up professorial appointments in the medical colleges, but those who had received European degrees in addition to their local diplomas, were quite fit.

(Lieutenant-Colonel Bhola Nath.) He did not think that the private practice of Indian Medical Service officers had declined. Among Europeans it could not possibly have declined because in Bombay, which contained a large number of Europeans, there were only one or two independent European practitioners and most of the European private practice was confined to the Indian Medical Service. But as regards their practice among Indians, it might have declined because a number of highly trained Indians with European degrees were available, and they might have taken up some of the practice which had been a virtual monopoly of Indian Medical Service officers before. He did not think that there was any racial prejudice behind it. Europeans also had no prejudice against Indians, provided they were specialists in their subjects. He said that a former Governor of Bombay had consulted an Indian specialist.

(Colonel Banatvala.) He did not consider that the standard of medical education imparted in this country was low. In his opinion except in midwifery, it was as good as that imparted in other countries, and that had been testified to by high officials like the late Sir Pardey Lukis. He thought that there was still room for improvement, and therefore he had advocated the recruitment of highly qualified specialists for professorial appointments and also for research work.

In his written statement he had said that Indian army medical corps officers should not be allowed private practice. In the first place, officers in charge of military hospitals could hardly be specialists in gynaecology or ophthalmology or subjects like these. In the second place, if military officers were allowed private practice, the civil medical officers might feel aggrieved that their practice was being taken away by these men. This was not his own personal opinion but the considered opinion of the Union.

(Mr. Hignell.) The Union was established in 1883. It was open to all doctors possessing qualifications which were recognised by the General Medical Council of the United Kingdom. There was no distinction of race, colour, or creed.

21 March 1919.]

The Hon'ble Major-General W. E. JENNINGS.

*(The schemes and questions referred to by witnesses are contained in Volume III.)***At Bombay, Friday, 21st March 1919.****PRESENT:**The Hon'ble Sir VERNEY LOVETT, K.C.S.I., I.C.S. (*President.*)

MAJOR-GENERAL G. CREE, C.B., C.M.G., A.M.S.
 MAJOR-GENERAL P. HEHIR, C.B., C.M.G., C.I.E.,
 I.M.S.
 MAJOR-GENERAL H. HENDLEY, K.H.S., I.M.S.
 THE HON'BLE MAJOR-GENERAL G. G. GIFFARD,
 C.S.I., I.M.S.

S. R. HIGNELL, Esq., C.I.E., I.C.S.
 LIEUTENANT-COLONEL A. SHAIRP, C.M.G., Indian
 Army.

MAJOR M. T. CRAMER-ROBERTS, D.S.O., Indian
 Army.

and, as co-opted members SIR T. NARIMAN, KT., the HON'BLE COLONEL H. E. BANATVALA, C.S.I., I.M.S., and
 LIEUTENANT-COLONEL BHOLA NATH, C.I.E., I.M.S.

MAJOR A. A. MCNEIGHT, I.M.S. (*Secretary.*)

The Hon'ble Major-General W. E. JENNINGS, M.D., I.M.S., Surgeon-General with the Government of Bombay.

*Written statement.**Questions for witnesses.***I.—A.—Defects in the organisation of the Royal Army Medical Corps and the Indian Medical Service in India.**

(a) *R. A. M. C.*—The officers of the corps depend more upon specialists than was intended by the appointment of these latter with the result that much ordinary work is thrown on to specialists and the self-reliance of officers is apt to become restricted.

The necessity for maintaining the strength of the Corps at a larger degree than is necessarily required for ordinary routine limits the work of officers and their chances of acquiring experience and self-reliance.

Professional work being limited naturally leads to the paying of undue attention to the routine of military medical administration inducing a habit of mind more or less prejudicial to professional efficiency.

The system of invariably appointing an officer of the Corps as Director, Medical Services in India, is not conducive to efficiency, particularly if such an officer is not conversant with the conditions and needs of the Indian army and has not had long experience of India and become expert in tropical diseases and their treatment. It moreover generates the mental attitude (which large number of officers from field service complain of) implying the idea of a superior or ruling service. This attitude probably led to the fact that officers of the Corps held the bulk of the administrative appointments in the field in the recent wars, while Indian Medical Service officers senior to them in the service were not only relegated to inferior positions, but not given full opportunity of employing capabilities acquired in special civil work. As an example I would quote one complaint which has reached me. Quite recently in East Africa there were 9 regular Royal Army Medical Corps and 13 Indian Medical Service officers. All the Royal Army Medical Corps officers had temporary rank, the senior being a temporary colonel (in which rank he was afterwards confirmed) and all the others temporary lieutenant-colonels though several had only 4 to 8 years of service. Only 4 Indian Medical Service officers got similar temporary promotion, though there were several of well known professional ability.

The practice of limiting the appointments of Deputy Assistant Director, Medical Services (Sanitary), to officers of the Corps is also a drawback because of

want of knowledge of Indian conditions and of familiarity with tropical diseases.

Early promotion has placed a number of officers in a senior position to officers of the Indian Medical Service with longer service.

Officers of the Corps almost invariably exhibit a marked dislike to having anything to do with Indian troops or to be in any way associated with the work or duty falling to Indian Medical Service officers.

The medical treatment of men of British troops cannot as a rule be carried out with equal efficiency by officers coming to the tropics for brief periods as by officers permanently residing in India.

(b) *I. M. S.*—The pay is inadequate being less than that of other military services in India. In any revision the fact must be remembered that private practice, as it used to be obtained, is non-existent now. In the recent pronouncement about increase of pay no mention is made of the administrative grades, though revision in that connection is urgently necessary.

The work of officers who elect to serve on the military side is uninteresting in the extreme. Indian military hospitals are poorly built and worse found in equipment and amenities, and afford no opportunities of improvement in professional knowledge. The station hospital system might improve these drawbacks in time, but so far the details of the change, while remedying some defects, do not promise to strike at the roots of the evil.

Duties have very much increased of late years without corresponding increases of allowances, while on the other hand certain allowances have been cut down.

Officers' expenses have been much increased by the increased cost of living at Home and abroad and although their Home remittances are heavier, they have recently been deprived of exchange compensation. Officers have to work every day of the year whereas combatant officers get two holidays per week (Thursday and Sunday): yet there is no compensatory privilege in the way of earlier pensions.

Transfers are frequent and owing to inadequacy of transfer allowances, medical officers are at a disadvantage.

Family provision is inadequate and badly arranged. Pensions for sons cease too early and for daughters are lost for good on marriage, not reverting in case of early widowhood. In the event of early death of the parents the children's pensions are barely suffi-

21 March 1919.]

The Hon'ble Major-General W. E. JENNINGS.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

cient for maintenance. Pensions promised under the Royal Warrant are not given, if an officer dies after retiring. These and service pensions should be guaranteed by the British Government.

There is a danger if a large number of temporary lieutenants be taken on permanently without adequate safeguards, that a wall of senior officers, all Indian, will block European recruitment for years to come.

Officers seldom get the leave to which they are entitled under the Civil Service Regulations owing to deficiency in the reserve.

B.—Schemes.

Schemes C and D appeal to me as capable of modification to provide what I consider to be the only solution of the defects indicated above, and others, and that is a combined military and civil medical service for India. I append the skeleton of such a scheme to these replies and the manner in which either of the schemes referred to could be modified is indicated in the main requirements given.

2. I consider the scheme I recommend, would meet with the approval of the War Office and meet with the needs of the army in India. The system hitherto obtaining of mobilising personnel for medical units by indenting on several departments or sections of departments is cumbersome owing to much divided responsibility and can only result in inefficiency as evidenced by the failures in Mesopotamia. Much of the personnel was untrained and many individuals were relegated to duties not consistent with their previous avocations or castes. Hence the necessity for a unified trained corps with a trained reserve.

3. I consider that the scheme I recommend would attract a good stamp of recruits and meet the demands of professional opinion in England and in India. Should it fail in either respect the remedy would depend on the particular deficiencies in the scheme leading to the failure, which only a trial could indicate.

4. It is impossible to appraise accurately the detailed results of withdrawing European medical officers from charge of troops, civil districts and jails in India. There was practically no difficulty in getting members of the medical profession to fill their places and their work was carried on temporarily tolerably satisfactorily. War conditions possibly induced those most concerned to desist from making objections which might fairly be raised in normal times and it is, therefore, probable that in all cases the arrangements could not be permanent. Speaking for civil institutions, while not in a position yet to refer to quality, the statistics indicate an appreciable falling off in the quantity of work in those stations in which civil assistant surgeons replaced Indian Medical Service officers after 1914.

5. The scheme I recommend is intended to meet all the needs of the civil administration in India and, as it provides for an ordinary as well as a special reserve, it should stand the strain of war on a large scale.

6. I think the ordinary reserve would meet military demands. If not, the special reserve could be called on.

7. The scheme I recommend, provides for training which I consider to be essential. The whole of the special reserve need not be always actually present in India but, if not, absent members should be capable of being called up within a reasonable time.

8. The Indian medical reserve (civil side) has been very largely mobilised for war and has been of value in thus being available. There can be no doubt that the special abilities of many officers so called up have rendered them very useful, but some have complained that they were relegated to positions in which their special capabilities were not employed or taken full advantage of. Such would not be the case under a unified service.

9. The system of recruitment and education I would advocate is indicated in the appended scheme.

10. I consider study leave essential and my suggestions are given in the leave rules of the appended scheme.

11. I am strongly in favour of research and consider that a special department would stimulate it. The details should be left to a committee of experts, but in the meanwhile research should enter largely into the curriculum of Tropical Schools as these become established.

12. Private practice has in its complete signification passed completely out of official hands. The main cause is the growth of an independent medical profession in India capable of affording relief at very much lower rates. I have also been given to understand that there are bodies of Indian practitioners pledged never to consult European officers of the Indian Medical Service. The bigger practice being among Indian Chiefs would appear to have suffered by restrictions put thereon by the State.

Questions to be asked of service officers.

1. Approximately a quarter of my service has been in military service and three-quarters in civil service.

2. I share in the prevailing discontent of the Indian Medical Service conditions indicated in reply to question 1 of questions for witnesses. So far as I am personally concerned, I have not enjoyed anything like all the leave to which I was entitled by the Civil Service Regulations and all unused leave earned lapsed on my promotion to the administrative grade. Even certain concessionary leave to which I was held to be entitled for special duty lapsed because of my not being allowed to avail myself of it within a certain time without any compensation being given me. I found the remuneration of an Assistant Director, Medical Services, inadequate for the responsibilities and work, and not sufficient to keep up the prestige of the position.

3. Throughout my regime as an Assistant Director, Medical Services, and before and since, I have been aware of an undercurrent of friction between the Royal Army Medical Corps and Indian Medical Service which seldom became in any way acute but was always present.

The differing conditions of the two services leads to a lack of cohesion, and there is a tendency on the part of the Royal Army Medical Corps to assume the roll of a superior or ruling service. Rapid promotion of Royal Army Medical Corps officers has made them wrongly senior to Indian Medical Service officers with more service.

There is a jealousy on the part of the Royal Army Medical Corps officers of the facilities Indian Medical Service officers have of improving their professional and financial status in civil work.

Indian Medical Service officers have complained of being inferior positions in the field and of an unfair division of honours and awards, etc.

4. Nothing can palliate or neutralize such causes of friction, except abolition of the system under which they have to work side by side, and the establishment of a single medical service for the British and Indian Army. A scheme for such a service is being submitted.

5. (a) Four years at a time.

(b) Not less than one year.

Special questions.

1. I should think roughly that the demand of European members of the public services for European attendance on themselves and their families are based on racial predilection in about two-thirds and on comparative professional merits in one-third of the cases. This is pure conjecture, but the racial question arises mostly in the cases of ladies and their children, while men are quick in recognising comparative merit.

21 March 1919.]

The Hon'ble Major-General W. E. JENNINGS.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

2. I am not in a position to say to what extent Europeans have been satisfied during the war. Probably people have refrained from complaining on account of war conditions of what in normal times they would object to. I know of instances in which Europeans have gone elsewhere to get European treatment, and I think that, so far as is possible, persons entitled to free attendance should be provided with the kind of attendance to which they have been accustomed all their lives.

3. I have reason to think that the best men have not been competing for the service in recent years.

Medical Stores Department.

1. Government medical stores.

2. The responsibility for indenting rests with the medical officer in charge. The most convenient arrangement, except in urgent demands, is to obtain supplies from the Government medical stores. There would be no objection, in the circumstances mentioned, to increased manufacture in India.

3. No suggestions.

*Questions to be asked of officers regarding assistant surgeons and sub-assistant surgeons.**Civil sub-assistant surgeons.*

1. Forms of prescribed bond are attached.* The only change during the war was to increase the penalty to Rs. 1,000. Any further change will depend on the policy of Government with respect to foreign military service. If such be enforced, I have strong reason to believe that recruiting will be affected unless better terms than at present exist, are offered. There has not been much difficulty in enforcing the conditions. Out of 116 detailed for military duty only 24 preferred to pay the prescribed penalty and resign.

2. I think there would be considerable difficulty in renewing the bond after the first five years, but the original period might be increased from five to seven years as in the case of military sub-assistant surgeons.

3. There is considerable discontent in the service especially among the junior men. This is due to the raising of the standard of preliminary education, the lengthening of the course from 3 to 4 years and the making of the Licentiatehip of the College of Physicians and Surgeons compulsory. This discontent could be assuaged by offering better pay and offering appointments in the provincial service to those who take the membership of the college.

Civil assistant surgeons and sub-assistant surgeons.

4. There was no difficulty in getting substitutes for civil assistant surgeons during the war but considerable difficulty in the case of sub-assistant surgeons. The drafting of these to military duty entailed the closing down of some dispensaries and many appointments in civil hospitals remained unfilled. Either the number of civil sub-assistant surgeons should be increased or increased facilities given in the medical schools for the training of private pupils of this class. At present the numbers are very much limited owing to lack of accommodation.

Civil assistant surgeons.

5. It is desirable that civil assistant surgeons should sign an agreement to serve in the military department in case of necessity but, without improvements in their pay and prospects, there would be difficulty in recruiting. The agreement should be binding for the whole period of their service and they should have periods of military training.

6. I do not think that the present arrangements adequately meet the ordinary requirements of the general population and the State. More dispensaries are needed and there is scope for more medical men. As regards control, there is room for modification in the

relationship of dispensary committees towards the medical staff. This latter should be entirely under the civil surgeons and no direct interference by committees should ever occur.

Military sub-assistant surgeons.

7. The military sub-assistant surgeon should fill a similar roll in the Indian station hospital as the civil sub-assistant surgeon does in a large civil hospital. He would undoubtedly be capable of performing the duties of resident medical officer and he could be utilized outside of the hospital for sanitary duties in lines or attendance upon families.

8. The training of military sub-assistant surgeons, beyond special attention to squad and stretcher bearer drill, is the same as that given to civil sub-assistant surgeons. From a professional standpoint it is adequate but it would be a great advantage if military pupils could be attached while training to a military hospital for a time to study military routine and regulations. They would thus be better equipped to start their military work at once on passing out. It would also be of advantage in training centres to have combined civil and military hospitals. The civil sub-assistant surgeons could then receive the training necessary to form part of the reserve.

9. The military sub-assistant surgeon as compared with the civil in the war was superior in military administrative routine, while the civil was generally superior in professional work.

Assistant surgeons and sub-assistant surgeons.

10. Unless combined civil and military hospitals come into force, there would be great advantage in attaching civil assistant and sub-assistant surgeons to Indian station hospitals both from the point of view of increased medical relief and of training them to form a war reserve.

Sub-assistant surgeons.

11. The status of sub-assistant surgeons has already been improved to a certain extent and recruitment is fairly well maintained. Any further improvements will depend largely upon the policy which Government might decide to adopt with regard to military service. As already stated, if the agreement be made to cover a longer period, and if foreign military service be included, then a decided increase of pay and prospects will be necessary to attract men.

Military assistant surgeons.

12. The role now filled by military assistant surgeons in British station hospitals is unnecessary. In many of his duties he could be replaced by non-professional trained men, e.g., his lay duties as in sub-medical charge could be carried out by quartermasters and clerks, his sanitary duties by trained Royal Army Medical Corps men and his work as resident medical officer by junior officers of the Royal Army Medical Corps, either in residence or taking turns of continuous duty in hospitals. This would not necessarily increase the cadre of the Royal Army Medical Corps.

13. In the military department appreciably, in the civil practically not at all.

14. Recruitment for the class should stop at once. Those at present on the strength could continue to be employed as at present till absorbed, or employment might be found for them in countries to be developed after the war. Retirement should be encouraged by the offering of gratuities.

15. I think recruitment of the class should stop as at present educated.

16. I would not be in favour of recruiting the class even if their education were raised to the standard required to obtain a registrable qualification in the United Kingdom as such would place commissions or civil appointments within their reach and they would certainly not join the class as at present constituted.

17. *Vide* reply 16.

18. The class should be abolished altogether.

* Not printed.

21 March 1919.]

The Hon'ble Major-General W. E. JENNINGS.

[Continued.]

*(The schemes and questions referred to by witnesses are contained in Volume III.)**Skeleton scheme.***1. COMBINED MILITARY AND CIVIL MEDICAL SERVICE FOR INDIA.***Reasons.*

(a) The formation of combined station hospitals for the treatment of the sick from European and Indian units.

(b) The actual formation of combined medical units mobilised for field service.

(c) The maintenance of a war reserve.

2. A DISTINCT INDIAN MILITARY MEDICAL SERVICE.*Reasons.*

(a) The necessary recruitment of Indian for commissioned rank.

(b) Short tours of service in India are in the case of Europeans prejudicial to the acquirement of knowledge of the languages, customs and caste peculiarities of Indians, without which there can be no real sympathy between the European and Indian members of the service, and between European medical men and their Indian patients.

3. ORGANIZATION.

(a) Commissioned medical officers—European and Indian.

(b) Nursing sisters.

(c) Quartermasters.

(d) Sub-assistant surgeons, who should rank as jemadars, subadars and subadar-majors.

(e) Clerical and dispensing section.

(f) Nursing section—European and Indian.

(g) Cooking section—European and Indian.

(h) General duty section—Bearers and ward servants. Bhisties. Dhobies. Mehtars.

Military assistant surgeons are designedly omitted: reference to them will be made under the heading "Adjustment."

With the above organization the "Service" becomes a "Corps"—The Indian Medical Corps. The dignity of the Corps would be enhanced by the prefix "Royal."

4. RECRUITMENT.

(a) *Commissioned medical officers.*—A competitive examination to be held at regular intervals in London.

It is suggested that the precedent of the civil services be followed, and that a combined examination be held for candidates for all the Medical Corps and Services of the Empire. Indians to be eligible for the Royal Indian Medical Corps only. With this exception the regulations at present in force for the examination of candidates for admission to the Royal Army Medical Corps should be adopted.

Before appearing for the entrance examination, Indian candidates should undergo a course of training at a recognized hospital in the United Kingdom, with a view to learning something of British ways, manners and customs; also of British methods of sanitation, hospital treatment and dietary, and other features of western medical practice.

To secure a sufficiency of Indian candidates, and to assist those who cannot afford the long residence in the United Kingdom, it is proposed that scholar-

ships, corresponding in number to half the average annual number of vacancies in the Royal Indian Medical Corps be offered for competition in India among selected graduates of the Indian medical schools. Each scholar should be tenable for two years. No scholar should be eligible to compete at the entrance examination for the Royal Indian Medical Corps, without the production of evidence satisfactory to the Secretary of State that he has completed at least one year's study at a recognised medical school in the United Kingdom; such evidence would ordinarily include a British medical qualification. A scholar should cease to draw his scholarship from the date on which he commences his salaried career as an officer on probation in the Royal Indian Medical Corps, in the event of his not having completed his tenure before that day.

To maintain a close connection between the military medical corps of the Empire it is suggested that an "x" percentage of the officers' cadre of the Royal Indian Medical Corps be reserved for officers of the Royal Army Medical Corps, to be nominated by the Director-General, Army Medical Service from officers of that Corps who volunteer for service in India. A secondary advantage of this suggestion is that a certain proportion of Royal Army Medical Corps officers will gain experience in tropical diseases. Such officers should be below the rank of major on nomination, and should decide before the completion of 5 years' service in India, and in every case before the attainment of the rank of major, whether they elect for permanent service in the Royal Indian Medical Corps, or for reversion to the Royal Army Medical Corps.

It is not possible to appraise "x" now, but it is suggested that it bear some relation to the relative number of British and Indian soldiers in the Indian army. The total number of Royal Army Medical Corps officers in the Royal Indian Medical Corps, both incorporated and serving temporarily, should at no time exceed this "x" percentage.

(b) *Nursing sisters.*—After absorption of the Queen Alexandra's Military Nursing Service for India in the Royal Indian Medical Corps, recruitment should be on the following principle:—A fixed proportion to be nominated by the Director-General, Army Medical Service, from the Home Army Nursing Service; the remainder to be recruited in India from the staff of recognized hospitals.

(c) *Sub-assistant surgeons.*—To be recruited as at present, but to rank as jemadars, subadars and subadar-majors. The inclusion of this class of officer in the corps is necessary to provide medical attendance for small outposts and other similar duties.

(d) *Clerical and dispensing section.*—To be especially recruited from Indians literate in English. It is suggested that all clerks be trained in dispensing.

(e) *Nursing section.*—(1) *British.*—To be recruited partly from the Royal Army Medical Corps for a tour of service in India, and partly from British units in India. The Royal Army Medical Corps personnel, on termination of tour of Indian service, to have the option of reverting to the Home establishment, or of joining the Royal Indian Medical Corps permanently.

(2) *Indian.*—To be recruited according to caste, in numbers sufficient to meet war requirements.

(f) *Cooking section.*—(1) *British.*—Non-commissioned officers and men from the Royal Army Medical Corps cooking section for instruction and supervision.

(2) *Indian.*—(a) For British troops.—Mohamedans, Parsis or Native Christians.

(b) For Indian troops.—According to caste, as under nursing section.

(g) *General duty section.*—No special remarks are necessary.

N.B.—All Indians taken into the corps should be enrolled and attested and should be given all privileges enjoyed by combatants according to rank.

21 March 1919.]

The Hon'ble Major-General W. E. JENNINGS.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

5.—WAR RESERVE.

(a) *Officers.*—The war reserve should be:—

- (1) *Ordinary reserve.*—Officers serving in the civil branches.
- (2) *Special reserve.*—Private practitioners, who volunteer to undertake the performance of military medical duties in times of national emergency.

The civil branches, or ordinary reserve, should be composed of officers seconded from the Royal Indian Medical Corps, a certain number of appointments being reserved for officers recruited from among graduates of the Indian medical colleges; some appointments could be filled by military assistant surgeons till this class be absorbed.

The number of officers seconded from the Royal Indian Medical Corps would be regulated entirely by military considerations. A roster of applicants for civil medical employment should be kept, and officers seconded according to their position on the roster. Local Governments should, however, be able to apply for the services of suitably qualified officers to fill special appointments, such as, Principals of Medical Colleges, professorial posts, etc. Apart from officers appointed to such posts, it is suggested that the period for which an officer may be seconded should not exceed 4 years. At the termination of this period the seconded officer should return to military duty, but should be permitted to re-enter his name on the civil employment roster.

(b) *Nursing sisters.*—All nurses employed in Government civil hospitals should be placed on the war reserve.

It is suggested that the nursing sisters of the Royal Indian Medical Corps, should be eligible to be seconded for positions of importance in connection with large civil hospitals.

(c) *Sub-assistant surgeons and other ranks.*—The whole subordinate medical and dispensing personnel and menial establishment of Government civil hospitals and dispensaries should be considered as part of the war reserve.

(6) PROBATION AND TRAINING.

(a) *Officers.*—After passing the entrance examination, officers should undergo a course of training in discipline and military medical organization at Aldershot. Instead, however, of going to Millbank, it is suggested that officers of the Royal Indian Medical Corps should complete their probationary training at one of the tropical schools in India. This course of training should extend over 6 months. At its close, each officer should be required to pass the lower standard vernacular examination in addition to one in technical subjects. Munshis should be provided free by Government, and the reward for this preliminary examination abolished. Within 3 years of appointment every officer should pass the higher standard vernacular test.

Before the completion of 5 years' service an officer, not being an Indian, should be permitted to exchange with an officer of equal status in one of the military medical corps or services of the Empire.

The subsequent training of officers should include periods of study leave; but it should be recognized that periods of study leave at uncertain intervals can never replace entirely regular practice in the wards of a general hospital; and that such general practice must be provided if a general level of professional efficiency is to be secured among the officers of the Royal Indian Medical Corps. To furnish this general hospital practice, it is suggested that the combined hospitals for troops should include wards for women and children and for the treatment of the civilian sick among the population of the neighbourhood. When the city is close to the cantonment, the existing civil hospitals may have wards added for the accommodation of soldiers who are seriously ill; the soldiers with mild complaints could be treated in detention

wards near the barracks. When a considerable distance separates city from cantonment, it may be necessary to add wards to the station hospital for the sick of the civil population. Whichever course be adopted, the experience gained in the present war with mechanical transport will be invaluable.

In connection with every large cantonment there should be one combined infectious diseases hospital for the military and civil populations.

Further general hospital practice for officers of the Royal Indian Medical Corps could be secured by mobilizing certain sections of field ambulances for permanent use as travelling dispensaries. In ordinary times the officers with these sections would treat the sick in the villages; the more serious cases would be conveyed to the station hospital. In epidemic times such travelling dispensaries would be invaluable, not only to the population of the affected area, but also in protecting cantonments from the entry of infection.

In these ways the officer cadre of the Royal Indian Medical Corps which must obviously be in excess of the peace requirements of purely military units, could, while enhancing its value to the State, be utilized for the benefit of the civil population without encroaching on the legitimate expectation of practice of the civil medical men.

With a view to keeping the Royal Indian Medical Corps in touch with its sister corps, and acquainted with developments in military medical organization in the United Kingdom, it is suggested that an officer of the Royal Indian Medical Corps, not lower in rank than a lieutenant-colonel, be appointed as "liaison" officer to the War Office in London. The period of appointment should not exceed two years, and should immediately follow a tour of Indian service, in order that he may be familiar with developments in India.

(b) *Officers of the war reserve.*—Training is only suggested for the officers of the civil medical branches who are not seconded officers of the Royal Indian Medical Corp.

The best time to train these officers is on first appointment. Every officer should be attached to the Royal Indian Medical Corps for the first 6 months of his service. During this period he should be given temporary rank as lieutenant, and be employed as house physician or surgeon of one of the station hospitals. His military training would, therefore, be of value to him in his subsequent civil career. After 4 years' civil employment each officer would be attached for one month for training with a field medical unit during military manœuvres, or for a similar period to the field ambulance working as a travelling dispensary in the district in which he is serving.

(c) *Sub-assistant surgeons of the war reserve.*—Sub-assistant surgeon on first appointment to the civil medical departments should also be attached to the Royal Indian Medical Corps, for training. They should be called up periodically for training with the field ambulances which are touring in the neighbourhood of the hospitals and dispensaries in which they are serving.

7. ADJUSTMENT.

At the inception of the corps arrangements for guarding vested interests will be necessary:—

(a) The Director-General, Indian Medical Service, as the head of the medical organization of India, should rank as Lieutenant-General. He will be Director, Medical Services in India. The question of whether it will be necessary to appoint a Surgeon-General, ranking as Major-General, to carry on these duties under him must be left to future consideration. With this exception every officer, whether Indian Medical Service or Army Medical Service holding an administrative appointment should continue in his appointment till he has completed his term of duty. Subsequent promotion to administrative rank would be made by the Director-General, Indian Medical Service, with the reservation that an "x" percentage

21 March 1919.]

The Hon'ble Major-General W. E. JENNINGS.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

should be on the nomination of the Director-General, Army Medical Service, until such time as matters are adjusted in the manner indicated below.

(b) All permanent officers of the Indian Medical Service will be enrolled in the corps; and an "x" percentage of Royal Army Medical Corps officers evenly spaced according to length of service and nominated by the Director-General, Army Medical Service, in consultation with the Director-General, Indian Medical Service. Adjustment is suggested in two directions:—(1) promotion to the rank of lieutenant-colonels, should be to fill vacancies in the cadre of lieutenant-colonels, and not by length of service; (2) all Indian Medical Service officers, who have lost relative seniority through the rapid promotion of Royal Army Medical Corps officers since the outbreak of war, should have their positions restored by such antedating of their promotions to the ranks of lieutenant-colonel and major as is necessary. This proposal does not involve the grant of back pay.

(c) Any officer, Royal Army Medical Corps, nominated for service with the Royal Indian Medical Corps, who is below the rank of lieutenant-colonel, should be allowed to elect for permanent service with the Royal Indian Medical Corps before attaining the rank of lieutenant-colonel or the completion of 5 years' service, whichever comes first. The right of the Director-General, Army Medical Service, to nominate officers, Royal Army Medical Corps, to military administrative appointments in India should cease when the senior Royal Army Medical Corps officer so incorporated is placed among the lieutenant-colonels selected for promotion.

(d) The nursing sisters of the Queen Alexandra's Military Nursing Service for India should be given the option of permanent service in the Royal Indian Medical Corps. Any further vacancies should be filled as suggested under recruitment.

(e) The following suggestions are made with regard to the military assistant surgeons:—*

- (1) All further recruitment should cease. This is really inevitable. The raising of the preliminary educational standard and the extension of the period of medical study to 5 years, will enable these men to obtain registrable medical qualifications, and thereby place commissions in the Royal Indian Medical Corps within their reach. Appointments in the civil medical department will also be open to them.
- (2) The retirement of military assistant surgeons in military employ at the inception of the Royal Indian Medical Corps should be encouraged by the offering of gratuities.
- (3) Employment for some military assistant surgeons may possibly be found in countries to be developed after the war.
- (4) The surplus can be employed in the Royal Indian Medical Corps on duties similar to those which they are carrying out now. Some of the vacancies caused by retirement will be filled by sub-assistant surgeons, and others by the attachment of recruits for civil medical employment.

8. CONDITIONS OF SERVICE.

The first commission of officers should date from the day on which the list of successful candidates at the entrance examination is published. This should apply to all the medical corps and services of the Empire. This list would then become a guide to the relative seniority of medical officers of equal rank serving in different parts of the Empire.

Promotion.—The following rules are suggested:—

- (a) An officer should be promoted to the rank of captain after the completion of 3 years' service, provided he has passed such qualifying examination as may be in force

at the time. Failure to pass this examination in time should ordinarily entail loss of seniority; but the antedating of the promotion of officers, who from unavoidable reasons have been prevented from appearing for the examination within the requisite period, should be at the discretion of the Director-General, Royal Indian Medical Corps.

- (b) Promotion to major should be after 7 years' service in the rank of captain provided the officer has passed the qualifying examination.
- (c) Automatic promotion to the rank of lieutenant-colonel after so many years' service should cease. There should be a fixed establishment of lieutenant-colonels, vacancies in which should be filled by selection from among majors, who have passed the qualifying examination.
- (d) The present rules governing accelerated promotion to the rank of major should be abolished, unless they should continue to be in force in the Royal Army Medical Corps.
- (e) Rules for brevet and substantive promotion for distinguished service should be the same as those in force for the army generally.
- (f) The number of surgeons-general, colonels and lieutenant-colonels in the Royal Indian Medical Corps will necessarily be fixed in accordance with the needs of the combined service from time to time.
- (g) The tour of duty for administrative medical officers should be limited to 4 years.
- (h) All officers should be compulsorily retired at 55 years of age; but officers who have been promoted to administrative rank may be allowed to serve up to 57.

It is suggested that the promotion of officers in civil medical employment be based on the following principles:—

- (a) Officers seconded for a 4 years' tour of duty should be promoted in accordance with the rules in force for the corps generally.
- (b) Officers seconded at the request of local governments, for longer periods than 4 years should be promoted up to the rank of major on the requisite number of years of service. A major should be promoted to lieutenant-colonel when the officer next below him on the active list of the corps has been promoted. Every officer of the rank of lieutenant-colonel, who has completed more than 4 years' continuous (exclusive of leave) service in civil medical employ, should be considered supernumerary to the fixed establishment of this rank in the corps.
- (c) Any vacancy in the fixed establishment of lieutenant-colonels caused by the seconding of an officer of that rank for civil medical employment not exceeding 4 years should be filled by a temporary promotion.
- (d) No officer of or above the rank of lieutenant-colonel, who has completed more than 4 years' continuous (exclusive of leave) service in civil medical employment, should be recalled to military duty unless his services be required in time of national emergency.

9. CONDITIONS OF SALARY.

Although there are solid reasons for a difference in the salaries to be drawn, respectively, by British and Indian commissioned officers, the experience of the exchange compensation allowance has proved that any such distinction would lead to discontent in the corps, and should be avoided. It is suggested that

21 March 1919.]

The Hon'ble Major-General W. E. JENNINGS.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

officers of the corps should draw salary in accordance with rank without regard to nationality.

If this be admitted, the first consideration in fixing the scale of salary must be the market value of the medical man in the United Kingdom, whose prospects have materially improved within the last few years mainly through the operations of the Insurance Act. These prospects are likely to be enhanced still further in the near future owing to the shortage of medical men, which will be one of the undoubted results of the war, and the possible future introduction of a State Medical Service in the United Kingdom. Faced with these facts, it is only possible now to indicate a scale of salary which will remove one of the great disadvantages under which officers of the Indian Medical Service have suffered for many years—the low rate of salary as compared with that of officers in other branches of the army in India.

In fixing this low rate of salary the right of private practice was a powerful factor. The paucity of candidates for the competitive entrance examination for the Indian Medical Service in the years prior to the war has proved that the possibility of private practice has ceased to act as an inducement to young medical men; so if Government wish to secure a good class of candidates the salary should be calculated on the whole time service of the officer. It should be left entirely to Government to decide whether private practice should be allowed in the case of any particular appointment.

The following scale of salary has been drawn up with the object of placing the officer Royal Indian Medical Corps on a slightly better financial footing than an officer Royal Engineer (India) in the Military Works of his own age. In this connection it should be remembered that the medical man bears the whole cost of his technical qualification, while the officer Royal Engineer is trained at the public expense, and draws salary at the same time:—

Table of salaries.

Lieutenant, on probation	(a) While in England and up to the time of joining the tropical school in India, he should draw the same salary as officers of equivalent rank Royal Army Medical Corps.
	(b) While at the tropical school Rs. 450.
Lieutenant	Rs. 620.
Captain, on promotion	Rs. 750.
Captain, after 3 years	Rs. 900.
Major, on promotion	Rs. 1,120.
Major, after 3 years	Rs. 1,275.
Major with 8 years' service	Rs. 1,450.
Lt.-Colonel, on promotion	Rs. 1,600.
Lt.-Colonel after 3 years	Rs. 1,750.
Colonel, A.D.M.S. Brigade	Rs. 2,125.
Colonel, A.D.M.S. Division	Rs. 2,250.
Surgeon-General with the rank of Major-General.	Rs. 3,000.
Director-General with the rank of Lt.-General.	Rs. 3,700.

It is suggested that within the corps there should be an organized "Public Health Section."

Attached to every station hospital should be a public health laboratory staffed by the requisite number of—

- (a) Bacteriologists.
- (b) Pathologists.
- (c) Chemical analysts.
- (d) Public health experts.

In the case of the smaller hospitals (a) and (b) on

the one hand and (c) and (d) on the other might be respectively combined in one officer.

The whole section should work under a colonel, Royal Indian Medical Corps, who should be on the staff of the Director-General, Royal Indian Medical Corps, and be designated Assistant Director, Medical Services (Public Health). It is suggested that he takes the place of the Sanitary Commissioner with the Government of India. The health of the army is closely connected with that of the civil population. As it is probable that in future the civil sanitary departments will be recruited locally, it is important, with a view to provide a link between military and civil public health measures, that the Sanitary Adviser of the Government of India should be the head of the Military Public Health Section.

On the staff of every Assistant Director, Medical Services of a Division, should be a Deputy Assistant Director, Medical Services (Public Health). An officer of the rank of lieutenant-colonel should hold this appointment as a rule; if, however, it be found necessary to appoint temporarily an officer junior to that rank, he should be given the local rank of lieutenant-colonel, without the extra salary.

It is suggested that "specialist" and "charge" allowances be abolished.

Rates of salary for officers in civil medical employment.

(a) An officer seconded for a period of employment not exceeding 4 years should draw salary according to rank together with any allowances attached to the post he holds.

(b) An officer selected to hold a special appointment should, if he hold the appointment longer than 4 years, draw the civil salary of the appointment on attaining the rank of lieutenant-colonel.

Explanation.

The civil medical appointments for which officers, Royal Indian Medical Corps, would be eligible are:—

- (a) Civil surgeoncies.
- (b) Port health officers.
- (c) Professorships.
- (d) Jail appointments, including Inspector-General of Prisons.
- (e) Principals of Government medical colleges.
- (f) Administrative heads of civil medical departments.

The tenure of appointments (a) and (b) should always be limited to 4 years.

An officer appointed to a professorship or as superintendent of a prison should ordinarily hold such appointment for 4 years; but, on the application of a local government, may be seconded for further periods of service, provided he undergoes at least one month's military training at the conclusion of each 4 yearly period, and decides before attaining the rank of lieutenant-colonel whether he wishes to remain in civil employment permanently. Should he remain in civil, he should draw the civil salary of the appointment.

An officer appointed as Inspector-General of Prisons, or as Principal of a Government Medical College, will generally be selected from lieutenant-colonels in civil medical employ. He should draw the civil salary of the appointment. When an officer in either appointment has completed 3 years' service as lieutenant-colonel he should be eligible for promotion to colonel (supernumerary) and should, after 4 years' service in the appointment with the rank of colonel, be qualified for the extra colonel's pension.

The administrative heads of civil medical departments should hold the designation of surgeon-general, and the rank of major-general, and draw salary as such. It is suggested that the provincial surgeon-general to the civil branch be Secretary to Government in the Public Health Department.

21 March 1919.]

The Hon'ble Major-General W. E. JENNINGS.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

10. LEAVE RULES.

The leave rules should be modified as follows:—

- (a) Officers should be allowed to accumulate privilege leave up to 4 months.
- (b) Officers should be permitted to take combined leave up to 12 months. Extension of combined leave involving absence from duty for more than this period should be granted only in the case of illness.
- (c) Every officer should on the completion of 4 years' continuous service in India, be required to take leave in a temperate climate for at least 6 months.
- (d) During his first 16 years' service every officer should be required to spend 12 months in approved courses of study in Europe or America. Each period spent in study should not exceed 6 months or be less than 4 months.
- (e) During privilege leave and periods of study an officer should draw full Indian pay of rank. During the remainder of his leave he should draw $\frac{2}{3}$ of the full Indian salary attaching to his rank at the time.
- (f) Officers proceeding on combined leave should, as far as possible, be detailed for duty on board troop-ships, or on hospitalships, if any be kept in permanent commission after the war. A hospitalship could take invalids to Europe at all seasons of the year, and would be the means of saving many valuable lives.

11. PENSION RULES.

It is suggested that the existing rules be modified in the following respects:—

- (a) Officers of the Royal Indian Medical Corps should be allowed to retire after the completion of 15 years' service.

- (b) The full pension should be on the completion of 28 years' service.

Scale of pension.

	£
After 15 years' service	260
After 16 years' service	280
After 17 years' service	300
After 18 years' service	320
After 19 years' service	360
After 20 years' service	400
After 21 years' service	450
After 22 years' service	500
After 23 years' service	550
After 24 years' service	600
After 25 years' service	650
After 26 years' service	700
After 27 years' service	750
After 28 years' service	800

A major-general, on the completion of the tenure of his appointment, should be entitled to an additional pension of £250 a year.

A colonel, on the completion of the tenure of his appointment, should be entitled to an additional pension of £150 a year.

Such gratuities as may be in force in the Royal Army Medical Corps should be given to officers who wish to retire on the completion of shorter periods of service.

Invalid pensions should be at the rate of £200 a year after 12 years' service; £220 after 13 years' service; and £240 after 14 years' service.

MAJOR-GENERAL JENNINGS, called and examined.

(President.) He was Surgeon-General with the Government of Bombay and had been employed as such since the 11th January 1919. He came from Poona where he had been Assistant Director, Medical Services, of the Poona Division for two years and two months. Prior to that he was Health Officer of the Port of Bombay and Presidency Surgeon, First District, Bombay. He had also previously held the posts of civil surgeon, Poona, and civil surgeon, Ahmedabad. He reverted to military duty as an Assistant Director, Medical Services, in 1916 and had now come back to civil as Surgeon-General. He had not seen any war service.

His own personal observation led him to say that officers of the Royal Army Medical Corps depended more upon specialists than was intended by the appointments of these latter with the result that much ordinary work was thrown on to specialists and the self-reliance of officers was apt to become restricted.

He considered it a defect in the organization that the Director, Medical Services in India, should always be taken from the Army Medical Service.

He agreed with Mr. Curtis's statement that the Bombay Presidency had been swept of its Indian Medical Service officers during the recent war, and that at the present time there were only 8 Indian Medical Service officers in civil employment in the presidency. This deficiency had, to a certain extent, been remedied by the promotion of assistant surgeons and the employment of independent medical practitioners. The work done by these promoted assistant surgeons had on the whole been fairly satisfactory in quality; the quantity of work done had, however, according to the returns received decreased considerably.

As regards the independent practitioners, they had done reasonably well. Their work in the army had been less satisfactory than in civil.

He could safely say that in the Bombay Presidency private practice had passed completely out of official

hands, except in the case of a few officers holding particular appointments.

He had, in his written statement, submitted an outline of a scheme which he thought would work satisfactorily. He was in favour of a combined military and civil medical service, and of the idea of having combined station hospitals for the treatment of sick, both European and Indian. Combined hospitals had been in use on active service and the same should now be done in peace time. He would have Royal Army Medical Corps and Indian Medical Service officers working in these hospitals—the Royal Army Medical Corps to attend to British troops and the Indian Medical Service to Indian troops. There should be one military service in India to look after both Europeans and Indians. This was not practicable at the present moment, but eventually it should be introduced. The service should be the same as at present in the Indian Medical Service, except that the Indian Medical Service would also have the charge of British troops. This service would have a war reserve which would be employed on civil duties. It would also have a leave reserve of its own. Recruitment for this service would depend entirely on military requirements plus the civil appointments which would be reserved for officers of that service. So far as the military were concerned he would recruit the corps on the basis of peace strength and war reserve.

He agreed with Mr. Curtis that the progress of western medicine had not made much headway in India, even amongst the most advanced and educated classes, most of whom still preferred to be treated by an Ayurvedic vaid or Unani hakim.

He had not much experience of medical officers employed on short terms in this country by municipalities or by companies, but personally he was of opinion that the short term arrangement was beset with difficulties.

He agreed with Mr. Curtis that a great deal might be done in co-ordinating the efforts of the military and

21 March 1919.]

The Hon'ble Major-General W. E. JENNINGS.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

civil. He also agreed that it would be a good thing if civil and military hospitals were amalgamated. Amalgamation would improve the civil officer from a military standpoint and the military officer from a professional standpoint.

(General Hendley.) Most of the local fund dispensaries were aided by Government. Their first supplies was provided by Government and after that they had to pay for them. There were comparatively few dispensaries kept by local funds and municipalities.

(General Hehir.) For purely professional work he considered that the provision of 4 Royal Army Medical Corps officers per 1,000 British troops was excessive. His experience had been that all military hospitals had been overstaffed.

He recommended the selection of the Director, Medical Services, alternately from the Indian Medical Service and Army Medical Service. This appointment should ordinarily be filled by an officer who had seen a good deal of Indian service. He considered that the appointment of Deputy Assistant Director, Medical Services (Sanitary), should be shared between the Royal Army Medical Corps and Indian Medical Service.

He advised the removal of the discrepancies that arose during the war owing to the early promotion of a number of Royal Army Medical Corps officers, with the result that they were placed in a senior position to officers of the Indian Medical Service with longer service.

With regard to the remark in his statement that officers of the Royal Army Medical Corps disliked treating Indian troops, the witness stated that this only applied to temporary Royal Army Medical Corps officers.

He considered that the leave reserve was insufficient.

He had heard complaints that the special talents of Indian Medical Service officers who had been reverted from civil to military duty during the recent war had not been used to the best advantage.

He was in favour of research work being conducted under an Imperial Department.

He considered that there had been undue interference on the part of Government in the question of fees. He had been given to understand from enquiries made that practice among Indian Chiefs had suffered in consequence of the limitation of fees.

He considered that, if the limit of service at which officers were to revert from military to civil and from civil to military employment were fixed by the Government of India provincial administration could not raise any objections. He was prepared to modify the time limit. Everytime an officer was promoted he should be made to do a certain amount of military training.

With regard to medical stores he advised the opening of secondary medical depots solely for the purpose of distribution. It would be conducive to efficiency if well trained business men were appointed to each of these secondary depots.

It would depend very largely on the attitude of the medical schools at Home whether, even after the main causes of discontent in the Indian Medical Service had been removed, the service would again regain its popularity. Personally, he was of opinion that if sufficient inducement were offered the service should again prove attractive.

Indian private practitioners in the Bombay Presidency were not capable of carrying out the duties of superior appointments, as capably as the Indian Medical Service officers who now held them. The teaching in the various medical colleges could not be carried out by independent medical practitioners as efficiently as by Indian Medical Service officers.

Nursing duties were not carried out efficiently in military hospitals in India. The arrangements for these duties required to be completely reorganised.

He favoured the conversion of the Indian Medical Service into a corps.

He considered that medical students in India received a complete medical education in the medical colleges.

He would be disposed to place all professorial appointments on an Imperial cadre with their own leave reserve.

He recommended the formation of an Advisory Board for the selection of officers to superior appointments.

He favoured the institution of promotion examinations prior to promotion from captain to major, but advised selection for promotion from major to lieutenant-colonel.

The training which he had received preparatory to taking up an appointment as Assistant Director, Medical Services, had been quite thorough, but the time allotted for the course was rather too short and it might be extended.

He did not think that administrative appointments in the army should always be filled by officers who had spent most of their service in military employ.

He was of opinion that there should be more administrative appointments carrying high rank in the military medical service. Formerly, there had been more of these appointments and when some of them were done away with, extra pensions had been given. The extra pensions had now disappeared and something was required to equalise conditions.

(Major Cramer-Roberts.) He would recruit for the British nursing section from the Royal Army Medical Corps and from British units. If there was any difficulty in obtaining men from British units he would recruit them all from the Royal Army Medical Corps.

(General Cree.) It was really necessary to keep a trained war reserve in civil in India. It was an advantage to the army to have officers who had been in military at some period of their career.

Under his scheme an officer would have to go to civil under certain definite rules. Those in civil would be given special appointments and in the event of mobilization they would be likely to be called upon to take up military duty according to the rank they were holding in civil.

He admitted the disadvantage of the present rule under which an officer, who might be a specialist in some branch of his profession, had to give up such work in order to be promoted beyond the rank of lieutenant-colonel. In order to obviate this, he was in favour of granting promotion up to the rank of colonel to officers performing purely professional duties, who might then be appointed as consultants. Promotion to the rank of colonel might also be given to officers in administrative charge of large hospitals. The rank of major-general would be reserved for officers holding general administrative appointments.

(Colonel Banatvala.) He was in favour of the creation of combined general hospitals to treat both troops and the civil population. He did not think the civil population would object to using the same hospitals as British troops. He was speaking really of hospitals that had come under his own observation.

(General Giffard.) The only difficulty in combining British station hospitals, Indian station hospitals and Indian civil hospitals would be in the matter of accounts, but this difficulty might be got over by working on a capitation system.

If there were a unified military and civil medical service, the military portion of it would be an Imperial service, while the officers in civil employ would belong to provincial services, to which they would be supplied by the Imperial service.

There would be no objection to having an Imperial civil pool from which all the different provinces could draw the officers they required.

He could not see how a certain number of civil appointments could be made irremovable, so that in time of war the incumbents of these posts would not be liable to recall to military duty. He feared that civil administrations would always have to put up with the inconvenience of having their officers taken away in time of war. He suggested that this difficulty might be got over by having understudies in civil, so that they could take the place of civil surgeons when the latter were called away for military duty.

(Mr. Hignell.) Personally he had no difficulty in interviewing the Governor whenever he desired, but he suggested that the head of the medical department should be a secretary to Government.

21 March 1919.]

Dr. R. Row.

(The schemes and questions referred to by witnesses are contained in Volume III.)

DR. R. ROW, M.D., D.SC., Honorary Temporary Lieutenant-Colonel, Indian Medical Service, Bombay.

*Written statement.**Question for witness.*

(1) The only scheme which commends itself to me is the scheme D subject to the modification and addition as herein specified in the appendix A. The reasons why this scheme as modified commends itself to me are (a) that its objects are to unify the services, (b) that it is conducive to a proper division of labour embracing military, civil, educational, purely professional and administrative sides of the same service, (c) that it aims at a fair and equal treatment to all the members who may be called upon to enter the service and (d) that it does not ignore the fair and legitimate claims of the Indians and Anglo-Indians in participating in this service, to the same extent as the other schemes.

(2) I am not in a position to say if the scheme as modified will meet with the approval of the War Office, but I have every hope that it will do so in view of the fact that it will ensure (a) an efficient and a regular military service to meet the requirements of the army in India and (b) an almost inexhaustible medical reserve to meet any emergency.

(3) I do consider the scheme as modified, will attract a good stamp of recruits and meet the demands of the profession both in England and in India as I am of opinion that it affords a great scope in the choice of a variety of careers, open to the members of the medical profession, be this a purely military—a strictly professional career, a rigid scientific one leading up to that of original research or that of a pure educationist and even one simply administrative. I think if this scheme as modified here, fail, no scheme will succeed in satisfying anybody.

(4) I am not in a position to say what has been the result of withdrawing Europeans from the charge of troops, but the result of their being withdrawn from jails and districts has been a great saving of money without any loss of efficiency and on the whole a smooth working of the whole pre-war machinery such as would justify a certain amount of pride and satisfaction to all concerned, that in a crisis, like the one we have just gone through, one could at a moment's notice call forth and satisfactorily utilise the reserve from the subordinate service so as to fill up the unavoidable gaps caused by the heads being called away on active service.

(5) The scheme, as modified, will meet the demands of the civil medical administration and it will not be affected by any war, even on a larger scale than the one we have gone through.

(6) Certainly. The supplement can be drawn from the members of the independent medical profession who can be called upon to take up honorary appointments and who can be trained as a supplementary medical reserve as indicated under the scheme D as modified, paragraphs 23 and 24.

(7) The military training as suggested for the civil branches of the scheme D will ensure such a reserve in India and its efficiency under proper military training will ensure its being utilised at a moment's notice, so that there will be no need for raising any additional reserve in England, for the sake of India. I am of opinion that the arguments that were hopefully cherished to justify the maintenance of a large medical reserve not only failed but the medical machinery would have collapsed had not the Indian medical profession—(chiefly the independent side of the same) been enabled to be drafted into the temporary commissioned ranks of the service at an extremely critical period of this war. [300 of the reserve of the Indian Medical Service (mostly Europeans) were called out for active service while 800 to 900 temporary commissions were granted to volunteers, all of these being Indians.]

(9) I should recommend recruitment for service as under scheme D (a), (b) and (c), page 2, by competitive examination held in England as at present and of (c) by competitive examination simultaneously held in England and India, when such simultaneous competitive examinations will be held for the civil service and other

public services in India, and for (d) by appointment by the Government of India on the recommendation after competitive examination held in some centre in India by a specially appointed expert examining board consisting of the representatives of the universities and other examining bodies in India, and for the honorary staff, both in the senior and junior grades, by appointment by the Government of India on the recommendation by the same expert board, on the strength of the work, merits and other qualifications of the applicants.

(10) Study leave in Europe, and America or elsewhere for 6 months every 5 years.

(11) Yes. This will form a separate chapter and will be outlined in a separate appendix which, I hope, I shall be able to get in print before the Committee meet in Bombay.

(12) I do not believe private practice has declined. On the contrary it has greatly increased chiefly on account of the efforts of the members of the independent medical profession who have during the last 20 or 30 years popularised the western system of medicine and its great advantages in the minds of the general public that this increase has not only generally benefited the officers of the present Indian Medical Service especially in towns and cities, but has enabled a great many of the highly qualified members of the independent medical profession to make both the ends meet in the face of a very unfair competition caused by the existence of official specialists maintained under Government patronage and Government pay. Any complaints as to the decline of private practice is to be explained partly by individual cases of professional incompetency but chiefly by tactless ways, probably unintentional, of dealing with private patients, and a complete ignorance of and prejudice and intolerance of local conditions and habits of the people.

APPENDIX A.

Modification and addition to scheme D as submitted by Dr. R. Row.

[Owing to some obvious printer's omission, the scheme is not serially paragraphed and I have taken the liberty to do so.]

Page 1, para. 1, line 2:—Add "and educational" after the word "civil." The para. will then read—

It is advisable if possible to have a unified medical service to supply all the medical needs of the Government of India both military, civil and educational and with this object, etc.

Page 1, para. 5:—Add at the end of the para.—

"And the proportion of (a), (b) to be as the numbers of medical officer for British troops are to those for Indian troops."

Page 1, para. 7:—At the end of the first sentence add the word "provided the proportion indicated in para. 5 is not disturbed."

Page 1, para. 9, line 10:—substitute, "instituting" in the place of "substituting."

Line 11:—Add after "Government of India."

On the result of a competitive examination (after obtaining a qualification registrable in England) held by a specially appointed examining board consisting of the representatives of the different Indian universities and other examining bodies.

Page 1, at the end of para. 9:—Add, "and such scholarships not to debar non-scholars from appearing at the open competition."

Page 2, para. 15 (a):—Add after 10 per cent. the words " (the proportion indicated in para. 5, page 1 being maintained in this 10 per cent.)"

Page 5 (b):—Add at the end of "whole time service," the words these to make up at present 40 per cent. of the whole civil cadre.

Para. 5 (c):—After "the whole time service" add these to be at least 40 per cent. of the whole civil cadre—

21 March 1919.]

Dr. R. Row.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

at present and then gradually to be increased up to 65 per cent. of the total civil appointments in the course of 15 or 20 years and later on by simultaneous competitive examinations held in England and India when such simultaneous examinations will be instituted in India for the civil service and other public services in India.

Page 2, para. 15, after sub-para. (c):—Add the additional sub-para. (d).

(d) 10 per cent. to be selected by open competitive examination from amongst the assistant surgeon class (Indian, Anglo-Indian and Domiciled Community) possessing qualification registrable in England—and appointed by the Government of India on the recommendation of the examining board referred to in this appendix (of para 9, page 1); the candidates so selected being under 28 years of age.

Page 2, para. 16:—Read (b), (c) and (d) in the place of "2 and 3", which is obviously a printer's error.

Page 2, para. 17:—Read "These three classes (b), (c) and (d) in the place of 2 and 3 which is obviously printer's error."

Page 3, para. 18:—Read the para. "The highest grade in the medical service, etc."—for "The higher two grades in the medical service, etc."

Page 3, para. 20:—In the place of "promotion to the two higher grades" read "promotion to the highest grade."

Additional paras. submitted to follow para. 23.

Educational and professorial branch.

24. In view of the generally accepted opinion that the medical education in India is defective to such an extent that the medical degrees and qualifications gained in India do not represent a complete medical education, it is essential to completely reorganise this important branch of the medical service and as this service is chiefly educational it ought to be considered in point of recruitment, pay and privileges as an entirely separate branch of the medical service, under the civil administrative Director-General of the medical service, and as the function of this branch is purely educational, it might legitimately claim an adequate grant from the educational department; which (grant) can be utilised to make up the personal allowance of the staff to be selected as outlined below. Owing to the important role this branch of the service will be called upon to play both in the training and education obtaining in the Government medical schools and also in the improvement of the professional and other qualities in the body of medical men who will be turned out by this branch of the service, it is of importance to attract to this service men of the highest quality from as wide a field of selection as possible and without any restriction of race or nationality; this will necessarily entail a great deal of expense. The plan of recruitment I propose to submit, is one which while ensuring a definite graded pay such as is outlined for the Bacteriological Department of the Government of India, for the sake of uniformity in the service, can be made elastic by the offer of additional or personal allowance (above referred to as claimable from the Educational Department) to be adjudged by expert advisory board under the Government of India to meet the requirements of individual cases of

extra brilliant men who may be thereby attracted to this career. They must be whole time men and their private practice to be very strictly limited to the minimum. The staff to consist of professors and assistant professors. The professors to be appointed by the Government of India on the recommendation of a strong advisory board of 5 professional experts, of whom a fair proportion may be non-service men. This advisory board may be requested to co-operate with a supplementary advisory board in London consisting of representatives of the Royal College of Physicians and Surgeons in London, Royal Medical Society, Royal Society of London, Society of Tropical Medicine and the medical advisers of the India Office, who may be requested to submit to the Indian advisory board after selection of suitable candidates, for their final recommendation and appointment by the Government of India.

The assistant staff to be selected by the Indian board on the merits and work of the suitable applicants, whose pay, etc., may be on the same scale as that of the assistant staff of the Bacteriological Department with personal allowance if necessary; these assistant professors, having an open door to compete for the higher and professorial grades when they are qualified to do so by virtue of their merit and professional worth; further this staff both senior and assistant or junior can be supplemented by the creation of an honorary staff from amongst the members of the independent medical profession and their selection and nomination being also adjusted on the strength of their qualification by the advisory board in India. These paid, as well as honorary staffs, both senior and junior to be subject to the same rules of discipline, military training, etc., with the regular members of the civil branch of the medical service as indicated in para. 17, page 2 of scheme D and to the corresponding temporary grade of the military service as indicated on page 3, para. 20.

Para. 25—Institution of honorary staffs in the districts both in the assistant surgeon grade as well as in the sub-assistant surgeon grade from amongst the practitioners of the independent medical profession and where possible even in the grade of district medical officers from amongst the better qualified men wherever such are available.

This supplement to the regular service from the honorary staff will go a great way to lighten the multifarious duties of the district officers and their assistants and will tend to increase the professional *esprit de corps* and lead to a much better relation between the different members of the profession, and the medical profession and the public than is to be found at present and it is needless to say that while saving the Government a great deal of money it will afford much greater medical relief to the public than at present. And by bringing this class of honorary workers under the same rules of discipline and military training as indicated in para. 20, page 2 of scheme D, one may count on an unlimited reserve for military purposes in times of emergency. These honorary members of the medical service especially of the junior grades may be allowed a small retainer or better still a small honorarium to enable them, to go to central places to specialise in their favourite subject so as to enable them to give the benefit of the knowledge so acquired to the district and rural areas.

Dr. Row, called and examined.

The witness was a private practitioner and a member of the Bombay Medical Union. He had been employed during the recent war at the Lady Hardinge War Hospital, Bombay, in an honorary capacity, and now held the rank of honorary temporary Lieutenant-Colonel in the Indian Medical Service.

He favoured scheme D with the modifications suggested in his written statement.

From his knowledge of Bombay, as well as of the districts, he was of opinion that the private practice of Indian Medical Service officers had not declined. On the contrary it had increased on account of the efforts of private practitioners to popularize the western system of medicine.

His practice extended to all classes of Indians as well as Europeans. Educated Indians used to call in *hakims* as well as doctors, but the practice was dying out. Private practitioners had ousted the *hakims* from the field to a great extent. The *hakims* were still holding their own in places where doctors could not exercise their influence. It was not a common thing for Indians of a good class to employ both *hakims* and doctors at the same time.

Private practitioners had to face unfair competition caused by the existence of official specialists maintained under Government patronage and Government pay. They were at a disadvantage in not having any facilities for work in Government hospitals. On this account

21 March 1919.]

Dr. R. Row.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

they suffered both in regard to their position and also from the lack of professional training which was only to be had by hospital practice. They should be attached to hospitals in an honorary capacity. In private practice, they had to compete with specialists maintained at Government expense. If he were an eye specialist, he would have to compete with a specialist engaged by Government and people would naturally prefer the latter. The private practitioner had to work very hard to keep up his reputation while the reputation of the service officer was guaranteed by the mere fact that he was employed as a specialist by Government. The ordinary procedure by which men became specialists namely, trying their hands on many cases and failing in a large proportion of them, was common to both the Government specialist and the private practitioner, but the former had greater facilities, and in course of time became more efficient. The complaint was that Government were maintaining a class of more or less artificial specialists.

The witness had been in private practice in Bombay for 21 years, and had a fairly large practice. There were in Bombay about a dozen doctors as well qualified as he, while the number with ordinary European qualifications was about 20 to 25. Most of them had qualified in India before going to England. There were practically none who had received their entire education in England. He himself had been educated at the Grant Medical College, Bombay, and had then proceeded to England. The practitioners, referred to above, were making good incomes which were on the increase. The demand for doctors qualified in the western system of medicine was increasing.

Many doctors who received their education in the medical colleges in India, and did not proceed to England had set up practice, and were doing well. To start with some of them did not do well but ultimately they succeeded.

(General Hendley.) There should, no doubt, be State hospitals managed by Government medical officers, but private practitioners should also be allowed to co-operate and should be given a chance of working in the hospitals. This object could not be secured by opening private hospitals as the expense would be great, though it would be very desirable to have them. An attempt was being made in Bombay to start a private hospital for which a philanthropist had contributed a large sum of money. The co-operation was going to man it by private practitioners who had offered themselves as honorary workers. The practice, followed in England, of selecting specialists for work in hospitals from among a large list of applicants should be procured in India. The real point was that as many honorary physicians and surgeons as possible, should be appointed in addition to the Government officers on the staff of each hospital.

A large number of private practitioners had been taken into service during the war. They had been granted temporary commissions in the Indian Medical Service. In the early stages of the war many who had actually settled in practice and had nothing to gain offered themselves and were taken. Out of the 200 offered by the Bombay Medical Union about 50 had been employed. They were persons with two to five years' experience, who had already settled down in practice. Some of them gained financially, but most of them did not join military service with the idea of improving their financial position. Later on younger men were asked for. It was a very good thing for them to join, and he would have been ashamed if they had not done so. They had nothing to lose, except the risks incidental to war. The later recruits were thus persons fresh from college, and they gained considerably by taking up military duty. In future really good practitioners with about 10 years' experience would be forthcoming for work overseas. The attractions of field service would induce them to volunteer, and they would be prepared to give up their practices. It would be worth their while to do so not only on financial grounds, but also because they would have a better position when they returned to their practices. He would fix the age-limit for recruitment at 28, so as to secure younger men whose character was not yet formed. Brilliant students qualified at about

22, though the average age on qualification was about 23.

(General Hehir.) The deficiency in the war reserve had been met very satisfactorily by Indian private practitioners. No doubt the war reserve had not broken down in any previous war, but there had not been any war like the last one before.

(Colonel Bhola Nath.) As a private practitioner in Bombay he had had no difficulty on account of European patients objecting to treatment by Indian doctors. They sometimes preferred Indians, especially in the case of diseases which they did not want to disclose to doctors of their own community.

It would be possible to get a certain proportion of the teaching staff from the private practitioners. There had been one or two on the staff of the Grant College, one of them was a private practitioner, and the other had been recruited from among the assistant surgeons.

The system of employing private practitioners as honorary physicians and surgeons had been tried, but not in the way in which it ought to have been tried. There had not been open selection, but nomination more or less. No one knew about the appointment till it was gazetted. It had not been tried in right earnest. He would certainly favour the extension of the system provided the selection was an open one.

The selection might be by an expert board such as could be got at Delhi, with the co-operation of a supplementary board in London. Applications might be invited, and selection made by the local board of experts with the co-operation of the Home Board. The men with the best qualifications should thus be selected.

Persons imbued with the desire of imparting knowledge would not insist on pay and would be prepared to work as honorary physicians or surgeons, provided they were treated as equals and provided they were allowed time to make their own living.

It would be possible to recruit a very large war reserve for the army from among private practitioners.

The statement that private practitioners were unfit for military duty after a few years' practice, as they began to suffer from diabetes and other ailments, was without foundation. Diabetes or any other disease was not the monopoly of medical practitioners, and they were not in any way more prone to them than any other persons. They had to work very hard to keep up their practice as they had to contend against officers who had great facilities, and this often told on their health. There was, however, nothing particular which would militate against their being utilized as a military reserve. They would not expect any remuneration, but would consider it a privilege and honour to be allowed to join this reserve.

In view of the fact that people got old earlier in India than in Europe, practitioners should be released from liability for military service after the age of 45 years. Private practitioners would not object to giving up their practice, and would volunteer for military training if they were given sufficient remuneration and proper rank during the period of such training.

A fixed proportion of Indians should be allowed to join the Indian Medical Service. The best men obtainable, whether Indians or Europeans, should, however, be selected. If the Indians who competed at the examination were not suitable and properly qualified, they should not be admitted. Admission should always be by open competition.

(General Giffard.) In reply to the question whether it was not contradictory to speak at the same time of having admission by open competition and of maintaining a fixed proportion of Indians in the service he pointed out that a large number of duly qualified Indians would be available, and that there would be no difficulty in securing the proper proportion of suitable Indian candidates. His object in suggesting a fixed proportion for Indians was to give them a fair chance. He would, however, object to the whole service being Indianized at the present stage. Europeans and Indians should be in equal proportions.

(Colonel Bhola Nath.) It would be a disadvantage to have the service Indianized, as both Indians and Europeans had much to learn from one another.

21 March 1919.]

Dr. R. Row.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

(General Giffard.) Private practitioners would volunteer for work in civil hospitals without pay. The head of the hospital should insist that the subordinate staff show the same respect to honorary as to official members of the superior staff. The trouble at present was that honorary workers were not treated on terms of equality, and were made to feel their position. The difference in this country was that there was nothing like a profession to which they could look for an ideal. The complaint that honorary physicians and surgeons would use the opportunity of work in the hospitals to their own advantage, by asking people to come to them, was not peculiar to India, and was a failing of human nature which could not be remedied anywhere. The honorary workers should, however, be under strict discipline, and subject to the same regulations as Government servants, and must be expected to work in the same way. They should be liable to dismissal if anything were established against them, no matter whether such a step raised an outcry.

SIR M. B. CHAUBAL, K.C.I.E., C.S.I., called and examined.

(President.) His views, except in one or two matters, were generally the same as represented in the various dissenting minutes which he had appended to the report of the Public Services Commission. The slight modification in his views was due more or less to what had transpired during the war.

At the time of writing the report, he was prepared to admit a third or even a higher percentage of Indian Medical Service officers into the civil medical service, but taking into consideration what had transpired during the war, he was inclined to think that a complete severance between civil and military would be preferable in the interests of both services.

The late Sir Pardey Lukis, when giving evidence before the Public Services Commission, had said that it was impossible to do away with the war reserve of the Indian Medical Service maintained in civil employ, because he thought that none of the private practitioners would volunteer in case of war. As the result of an enquiry, the same officer had found out that there were only 24 private practitioners in the whole of India, who would volunteer for field service in case war broke out, and that all of these were Europeans. The above statement could not be said to be true now, in view of what had been seen during the war. Some 800 doctors had volunteered, and they were all given temporary commissions in the Indian Medical Service. If as many as 800 could be got for war purposes, he did not see any necessity for the civil administration being dislocated in the way in which it had been during the late war by the removal of so many medical officers from civil duties.

Though a war reserve should be provided for, if it was absolutely necessary, still to keep up the expenditure on a separate war reserve, during the time of peace, did not stand to reason. The fact that many military officers worked in civil employ during peace time, showed conclusively that there was no necessity for these men ordinarily. If extraordinary times could be provided for by private practitioners and others volunteering to do war work, he did not see any necessity for the continued maintenance of a war reserve in time of peace.

He agreed that it was probably necessary to have doctors in the war reserve available at short notice when it was required to send a force on field service, but he maintained that this need would be met, if all medical graduates had undergone a military training as a necessary part of their course in the medical colleges. He wanted every private practitioner to understand that he would be bound to volunteer in the interests of his country in case of war; and he was sure that, if he was made to understand what was required of him, he would not be averse to do it. But he had not thought about the time which would be necessary to give medical graduates a military training.

He would not make the professorial chairs in civil medical institutions a close preserve for any one service. He would throw them open to all men in the British Empire. The best way, in his opinion, to fill up

He hoped it might be possible to fill professorial chairs in Government colleges by private practitioners without fees. His idea was great, and he earnestly hoped that doctors would come forward for the love of the work, after some years' practice when they had made their reputations and earned sufficient money. Only rich persons could afford to do so, others would require remuneration. Personally he would be glad to work gratis.

It would be a good thing for Government to subsidise private medical colleges in which private practitioners might have scope for work, but he would not prefer it to their being entertained to fill professorial chairs in Government medical colleges, as this would make a sort of unfair distinction, and would place a hall-mark of inferiority on them, and thus lead to friction. Such a system was no doubt in force in the education department, but conditions were different in the case of the medical profession.

these appointments was to advertise and to select the best candidates.

There should be scope for Indians to get into the higher posts in the medical service, so that the knowledge and experience which they would have gained during their service in these high posts, should not be lost to the country, if and when they retired. All the knowledge and experience gained by Indian Medical Service officers at present were lost to the country as none of them remained in this country after they had retired. This should be remedied as far as possible.

He said that there was a general complaint among the Indian members of the Indian Medical Service that they were not posted to the best civil stations. None but European members of the Indian Medical Service were posted to the best stations in the Bombay Presidency. This was the reason why most Indians in the service preferred to remain in military employ, as by so doing they had the chance of serving at all the principal stations. This was borne out by the late Sir Pardey Lukis' own statement that he was surprised to find on enquiry that while 87 per cent. of European members of the Indian Medical Service applied for transfer to civil, only 52 per cent. of Indian members of the service applied for transfer to civil.

(General Hendley.) He did not know whether most of the men who had been given temporary commissions were men just passed out of colleges. He knew as a fact that over 800 temporary commissions had been given and that many men who had been qualified sometime, had applied for them and failed to get them. He had no knowledge as to how many of the 800 were private practitioners.

He agreed that the policy of using the present war reserve for civil purposes during peace time was an economical one. But he did not see the necessity of keeping them permanently as a war reserve and employing them on civil duties, on higher pay, on the chance of being called out for war once in 100 years or so. He did not object to the leave reserve, but he objected strongly to military men being employed in the civil department. The civil population should not be deprived of medical aid even in time of war.

If there was a separate civil medical service, admission to it should be by an open competitive examination to be held in England, on the lines of the present examination for the Indian Medical Service, but, if anything, harder. He did not anticipate that there would be any scarcity of European candidates. On the contrary, there would be great competition for it.

His reason for advocating the separation of the civil from the military medical service was not based on grounds of economy, for he realised that the same number of medical officers would have to be maintained in civil, but in order that the civil medical cadre might be permanent, and its officers not liable for recall to military in the event of war.

(General Hehir.) He did not anticipate any difficulty in getting volunteers for any frontier war. At the most

21 March 1919.]

Sir M. B. CHAUBAL.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

only 100 or 200 men would be required. When 800 men had been forthcoming during the recent war, it ought to be quite easy to get 100 or 200, in view of the proposal which he had made earlier that every medical graduate should undergo military training as a part of his course.

(General Giffard.) If there was a separate civil medical service, it would give scope for a larger number of Indians to be employed in it. If this was done, the service, on the whole, would cost less. He was in favour of giving Indians less pay than Englishmen, even if they were as highly qualified, except in cases where Indians and Englishmen were working side by side. He did not desire to exclude Englishmen from the service. He thought that India would require them for a long time to come. He hoped that the prospect of lucrative private practice would attract very good candidates from England.

He did not think that the private practice of Indian Medical Service officers had declined of late. It might have declined in out of the way places, but not in cities. Private practice depended solely upon the in-

dividuals themselves. If they were really good men, they would have large practices.

It would not, in his opinion, be difficult to get men for the military branch of the Indian Medical Service, even though the civil branch were made as attractive as the military. In the first place, there were many to whom military life appealed. In the second place, if in the end it proved that the military service was not attracting the best class of candidates, their emoluments could be increased.

He was anxious to obtain the very best men for professorial appointments in the colleges and schools. He realised that, in order to attract such men in the open market, it would be necessary to offer much higher pay than that which professors drew under the present system, but he did not consider that there was any objection provided that really able men were obtained.

(Mr. Hignell.) He had been a member of the Executive Council of the Bombay Government during the war. His experience in that capacity had not led him to modify the views he previously held except as already stated in his evidence.

DR. MIRZA YAQUB BEG, L.M.S., Representative of the Punjab Medical Union.

Written statement.

I, as the representative of the Punjab Medical Union, beg to submit this statement; and I am sure that in my remarks I will be echoing the innermost sentiments and opinions, not only of the independent profession in India, but also of the Indian medical profession at large.

I.—THE FOUR SCHEMES.

The appointment of a Committee of Enquiry to record evidence indicates that grave defects have been discovered in the existing organisation of the military medical services in India. Those defects have not, however, been mentioned nor the results of various enquiries into those defects published to make the subject clear to the witnesses appearing before this Committee.

Of the four schemes proposed, it is impossible to approve of any one of them, as none of them is suited to the present requirements of India. Due regard has not been paid to the claims of the Indian medical graduates in general and the independent practitioners in particular; and little scope has been provided for the employment of Indians in the higher medical services of their own country. The claims of the independent medical profession were substantiated, by evidence before the Public Services Commission, for their demand for employment in State hospitals and in medical colleges to professorial chairs; and for facilities to avail themselves of the Government laboratories for clinical and research work. No recommendation to this effect have been made in the schemes and no provision made to do away with subsidised competition—an evil which exists under the present arrangements and which forms a great hindrance to the growth and development of the independent medical profession in India. There is no doubt whatever that, if Indian graduates are assured of an honourable field for their work, they would be encouraged to go in large numbers for higher qualifications like M.D., F.R.C.S., etc. At present such higher degrees do not offer any bright prospects as far as general practice is concerned.

Of the 4 schemes proposed by the Committee, A, B, and C are very detrimental to the interests of the civil departments and the Indian graduates, and do not create a wholesome change for the redress of the existing grievances. The scheme A is no unification of the services, but means abolishing the Indian Medical Service by replacing it by an auxiliary corps of Indians and Anglo-Indians, and practically shuts the door of higher service to the Indians; while the schemes B and C aim chiefly at enhancing the emoluments and scope of the present Indian Medical Service incumbents. These

schemes, if acted upon, will prove more expensive, and at the same time unsatisfactory. The scheme D might work better with modifications. All the schemes under reference unify the services, in one way or the other, and improve upon the existing medical administration of the army; but the claims of the civil population have in the most been ignored. It is highly essential that a higher civil medical service be instituted; and that the civil should be quite apart from the military, in order to meet the needs of over 300,000,000 people that constitute the civil population of India. There is no doubt that the Indian Medical Service incumbents have done yeoman's work in the field of medicine in India, and the Indian medical profession is indebted to them; but as at present there is no scarcity of recruits (either in India or in England) for civil employment, it is not advisable to continue to enter the civil through the portal of the military. Moreover the requirements of the civil are daily increasing, especially in the direction of research, sanitation and education; and it is impossible for the Indian Medical Service incumbents to cater for all of them. The present war has emphasised the necessity of creating a separate civil medical service, as in the event of a general mobilization, and the consequent withdrawal of the Indian Medical Service, the interests of the civil suffer very materially.

II.—THE SCHEME PROPOSED.

The military medical services should be quite separate from the Indian civil medical service which should be divided into Imperial and Provincial and sub-divided as follows :—

I.—IMPERIAL.

1. Educational (professors in medical colleges).
2. Research (specialists in each line).
3. Sanitary Commissioners.
4. Civil Surgeons (or District Surgeons).
5. Superintendents, Jail and Lunatic Asylums.

II.—PROVINCIAL.

1. Educational (Lecturers in Medical Schools, Assistant Professors and Demonstrators).
2. Research (assistants with good qualifications and training).
3. Deputy Sanitary Commissioners, Health Officers.
4. Assistant Civil Surgeons (or Deputy District Surgeons).
5. Deputy Superintendents.

21 March 1919.]

Dr. MIRZA YAQUB BEG.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

RECRUITMENT.

IMPERIAL.

A.—1 and 2, selection in open market—for best qualified men, Indian or European.

B.—3, 4, and 5 by an open competition in India and England, on the same lines and conditions as for the Indian Medical Service, at present. Pay and promotion should be the same.

C.—Promotions from provincial service.

NOTE.—Sanitary—B.Sc. in Public Health or D. P. H.

PROVINCIAL.

1, 2, 3, 4, and 5, situations to be secured by open competition in India.

Indians or Anglo-Indians with Indian or British qualifications.

NOTE.—Sanitary—B.Sc. in Public Health or D. P. H.

NOTE.—As a condition of service (both Imperial and Provincial) medical officers will receive military training, and will be liable to be called to military duty just as Territorials in England, and will form a military reserve in case of emergency. The vacancies in the civil could easily be filled by the private practitioner.

SCHEME D MODIFIED ACCORDING TO THE PROPOSED SCHEME.

I propose the following modifications in scheme D for the consideration of the Committee:—

The whole military medical services should be united. It should be divided into superior and subordinate medical service. In the superior medical service, the proposed "Indian Army Medical Corps," the admission should be by an open simultaneous competitive examination both in England and India. At least 33 per cent. to be recruited in India, rising by 1½ per cent. yearly, as recommended in the Montagu-Chelmsford scheme. So far as India is concerned the distinction between the Indian Medical Service and Royal Army Medical Corps should be abolished. Their pay and prospects should be identical. The method of recruitment should be the same as followed at present for the Indian Medical Service, and no restrictions should be placed upon the Indian medical graduates competing for this service. All colour, class and creed distinctions should be abolished. Indians as well should be placed in charge of British regiments; caste prejudices should not be fostered.

A recent pamphlet by the British Medical Association issued to all Indian Medical Service officers, and presented to the Public Services Commission and again to the present Secretary of State for India, and published in the British Medical Journal, instead of improving upon the existing conditions, is calculated to accentuate the feelings of racial distinction, which should no longer be fostered. That the honest Britisher has no prejudice against being treated by an Indian doctor, is conclusively proved by the fact of successful Indian medical practitioners in England, and even in India there are several Indian doctors who have an extensive practice among Europeans. It is most desirable that Indians and Anglo-Indians should live on equal terms with their fellow subjects of the British Empire.

Men who qualify themselves in England, in the competitive examination, specially the Europeans should be sent to India immediately for military, social, and language training, which should extend for one year; also for attending courses in tropical medicine and other subjects for which facilities do not exist in British hospitals. Those successfully competing in India, should be sent for one year to England, for military and social training and courses in any subjects for which at present the same facilities do not exist in Indian hospitals as in British ones.

Subordinate military medical service.

In this service all distinction between military assistant surgeons and military sub-assistant surgeons should be abolished. The qualifications should be improved. In fact none below the registration standard of British Medical Council should be admitted. A competitive examination for this service should also be held as has been recommended for the superior medical service. The standard would necessarily be lower for the subordinate service than for the superior service. The pay and prospects should be identical, both in the British and Indian regiments.

Civil medical services.

These should be totally independent of the military medical services, as sketched under the general scheme for the civil medical department. They should form a reserve for the military in times of crisis.

The Imperial civil medical service.

1. About 80 per cent. of the Imperial appointments should be recruited by an open competitive examination in England and India; 33 per cent. of this should be by a simultaneous examination in India, increasing by 1½ per cent. per year. The posts in the education and sanitary departments, and any others requiring special knowledge, should be filled by selection by an Advisory Board to Government, which should consist of official and non-official members, containing independent Indian practitioners as well.

2. Twenty per cent. should be filled up by promotion from the Provincial civil medical services of India, as already outlined under the Provincial civil medical service.

The Imperial service men recruited by open competition in India should proceed to England; and those entering it in England, to India, for military, social and other preliminary training.

Provincial civil medical service.

This should also be recruited by competition; and the members of this service should enjoy same privileges, as regards their pay, prospects, and status, as other provincial civil services (like those of Engineering and Judicial departments) as have been recommended by the Public Services Commission, and the existing grievances of the civil assistant surgeons should be removed.

Study leave.

The members of both the Provincial and the Imperial services should be given facilities and encouragement, to go to England for higher qualifications. Brilliant and specially deserving men, who have obtained special qualifications in Europe, should after 10 years' service, be eligible for promotion to the Imperial civil medical service of the country, as shown above. These promotions should usually take place between 10 and 20 years of service. Promotion to the Imperial service after 20 years' service in the Provincial should be exceptional as not only a man cannot do justice to his duties in advanced age, but a long subordinate position crushes out all initiative in majority of cases.

War reserve.

The civil provincial service men would also form a reserve for the military service in times of need. They should receive initial military training in the military colleges and at the station staff hospitals which should be established in India.

A three months' military training after every five years would be enough to keep them fit for military duty in times of need.

The experience of the present war has simplified the question of a war reserve, as 900 Indian medical men offered their services for the temporary Indian Medical Service and they performed the most arduous duties at

21 March 1919.]

Dr. MIRZA YAQUB BEG.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

the front. Therefore, there can be no scarcity of recruits at the time of war, if the services of the civil are utilized for the emergencies of the war, as has been recommended in my scheme.

It may, however, be pointed out that claim of the temporary Indian Medical Service men must be considered, and those that have distinguished themselves in the military service and possess qualifications registrable in Great Britain, should be made permanent; others, whose services are not required for the military, should be given a bonus or a retaining fee, so that their services could be utilized at a future occasion.

It may also be added that a large number of Indian practitioners held charge of military and civil medical duties honorarily during the time of the war.

Medical education.

The general standard of medical education should be brought to a uniform level as required by the British Medical Council. No qualifications below this should be recognised for Government employment.

Ward or hospital assistants should form a distinct class; not as medical men, but as mere assistants.

Military apart from the civil.

There is a distinct advantage in keeping the civil and military services apart. As at present it is acknowledged that the chief attraction for the Indian Medical Service is the civil medical service, and its privilege of private practice; need it be said that candidates entering under this allurements, capable though they may be, will not have a taste for the military part of the medical service, and thus not be suitable for military work.

Medical men desirous to join the military service should do so with full knowledge that they will have to remain in the military. To excel in that line, they must love that line. Give them better pay if the pre-

sent pay does not, or will not, attract men of the proper stamp.

It is necessary that these men should be masters of their art, experts in the military medical service; and civil reserves from the highest to the lowest grade should look up to these experts for advice and guidance in military subjects. They should form the central nucleus round which the civil reserve should crystallize. As at present the best men from the military service (Indian Medical Service) filter through to the civil, spend all their life in easy circumstances, get to the highest grades by forgetting all their military traditions, and when a call comes, some of them do not like it and try to avoid it by all possible means. Some of those that go back to the military will refuse to receive advice from their juniors who have remained in the military, and this causes friction and is said to have been the source of good deal of trouble during the war.

Moreover, the best men getting out of military work, leave behind only indifferent men to carry it on, or improve the military side of the medical relief, and this in itself is a serious loss to the military medical service.

III.—THE INDEPENDENT PRACTITIONERS.

The independent practitioners can form an efficient and least expensive war reserve. Their co-operation can be easily secured if Government were to utilise them, by giving them facilities to work in State hospitals as physicians and surgeons as had been recommended by Lord Morley and by the Public Services Commission. It is also desirable that they may be given chances of filling professorial appointments in the various medical colleges, and that as has already been recommended in my proposed scheme they may have facilities of keeping their patients in private wards of Government hospitals, and that they may be permitted the use of the pathological and bacteriological laboratories as well and that they may be exempt from the Arms Act.

DR. MIRZA YAQUB BEG, called and examined.

The Punjab medical union which the witness represented had less than 100 members. He had taken his degree at the Lahore Medical College in 1897, and had been employed for some time as House Surgeon in the Mayo Hospital. He entered service as a civil assistant surgeon. He had been in the mufassil for about five years and had later been employed in the medical college as junior demonstrator and assistant to the lecturer in anatomy. He had never been to England but was proposing to go there. He was making a good income. Graduates in western medicine practising in the towns of the Punjab were doing fairly well. The spread of western science had so far had very little appreciable effect on the practice of *hakims*. Educated classes in towns had to some extent deserted the *hakims*, but there was not much effect on the masses. Sometimes educated persons employed both doctors and *hakims* at the same time.

There was an increasing demand for efficient doctors. He desired his son to study medicine after he had passed the senior Cambridge examination. If he could compete for the Indian Medical Service or any other service which might take its place, he might go up for that, otherwise he might start private practice.

He did not approve of any of the schemes as a whole. Those who joined the civil medical service should have military training for about three to six months on entering the service, and should again have three months' training after every five years.

About five or six members of the Punjab Medical Union had gone on military service. One doctor had taken up the duty of examining recruits. Nearly eight members of the Union who belonged to Lahore had taken degrees in England, and there were five to ten others from outside stations who held such degrees.

(General Hendley.) With regard to the complaint that practically all the doctors in the Punjab who volunteered

for service out of India were very junior men, he explained that the Union had not been approached properly. Letters were issued from the office of the Inspector-General of Civil Hospitals to civil surgeons, who in turn issued letters to the practitioners. Many of them had established practices, and it was inconvenient for them to go abroad. Their services could have been utilised locally, and they could easily have formed a war reserve in India. He admitted that the terms were settled and issued broadcast, but independent practitioners were not properly utilized.

No provision was made in the scheme to do away with the system of subsidised competition. All the big Government hospitals were run by one service, the Indian Medical Service. By "subsidised competition" he meant that there was no fair field for the independent private practitioner. They could be utilised in Government hospitals, and would improve their efficiency considerably if they had this opportunity on equal terms. Without hospital experience it was difficult for them to excel in their work. In Bombay a post of honorary physician and surgeon to the Jamsetjee Jejeebhoy Hospital had been created, and this was open to independent practitioners. This should be done everywhere, and honorary posts should be given in big districts to private practitioners, and they should be allowed to attend to inpatients, some beds being allotted for them. He did not intend that private practitioners should be allowed to interfere in the direction and management of State institutions. They would join the hospitals as honorary workers. In smaller districts they should be given some sort of honorarium. They would be Government servants, in a way, and would be under the orders of the authorities as regards their work in the hospital. In a way they would be subsidized by Government. To the question whether these persons would not cease to be independent practitioners, he replied that

21 March 1919.]

Dr. MIRZA YAQUB BEG.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

the system was in force in England also. No doubt among private practitioners there were honorary workers, and in India, too, if private practitioners had sufficient income, they would work in an honorary capacity.

All medical men in India should have qualifications registrable in England, as the qualifications obtained in India, were, according to the evidence of the late Sir Pardey Lukis and others before the Public Services Commission, equal to the qualifications obtained in Great Britain. The degree qualifications, and qualifications registrable in England were in many ways equal, and Sir Pardey Lukis had observed that they were superior in many respects to the qualifications obtained in Great Britain. He pointed out one or two defects which could easily be removed. In the above remarks witness was referring to university qualifications.

The qualifications of military assistant surgeons and sub-assistant surgeons should be improved and they should have some sort of university training. From his 10 years' experience as a teacher, he could say that, though some of them were very good, many of them could not understand the subjects they were taught, because they had no previous scientific education. Their course should be increased to five years, and they should have some sort of university qualification.

(General Hehir.) His proposal would mean the complete extinction of the military assistant and sub-assistant surgeons. They should be replaced by better qualified persons. Of course, their pay would have to be increased, but they would be better qualified and more efficient. These classes would gradually disappear, as they were replaced by better qualified doctors. The late Sir Pardey Lukis had also held the view that the standard of education of military assistant surgeons should be raised to the level of civil assistant surgeons.

(Sir T. Nariman.) Twenty years ago medical students in the Punjab had had sufficient opportunity for training in midwifery. He himself had attended six labour cases. When he was House Surgeon he never called for the gynæcologist, and attended all of them himself, and it was only in case of difficulty that the professor of midwifery was called in. As regards opportunities for training students in midwifery, he explained that for the last 20 years there had not been many cases available as Indian women went largely to the zenana hospital for their confinement. Formerly there was a maternity ward in the hospital, in which no patient was allowed to remain if she objected to being attended by a student. That rule had been dropped for the last 20 years, and had given rise to the difficulty complained of regarding the want of scope for teaching midwifery in the medical institutions. There was, however, ample scope. Ladies had no objection to being treated by male doctors. All the difficult cases came to the hospital, and they generally preferred to be treated by male doctors. Major Bott had a good deal of practice in gynæcology, and most of the cases went to him rather than to the female hospital.

(Colonel Bhola Nath.) Civil assistant surgeons had several grievances some of which were given below :—

- (1) The principal one was with regard to their pay which was fixed 70 years ago.
- (2) Their status. They did not enjoy the same status and the same privileges as members of the Provincial civil service.
- (3) In the mufassil hospitals they could not get their proper share of work as compared with the civil surgeon.
- (4) They did not have a proper share as lecturers in the medical institutions.
- (5) They were transferred after five years which was detrimental to educational interests. This limit of five years should be abolished.
- (6) Those who were employed as lecturers were treated as demonstrators.
- (7) Those who were employed by Government should be treated as permanent unless they were found to be defective in any way.
- (8) Their pay as civil surgeons should be increased.

- (9) They did not like their designation. Some of them held M.D., M.B., B.Sc. degrees and it was anomalous to call them assistant surgeons. The designation of the service should be "provincial medical service" or some other suitable name.

Assistant surgeons as a class were quite efficient. The best graduates from the Lahore Medical College compared very favourably with the best men in the Indian Medical Service. Sometimes an Indian Medical Service officer could teach a junior assistant surgeon, and sometimes the latter could instruct the former. Each could learn from the other, and the question was really one of give and take.

Some of the private practitioners who had gained experience could easily take up professorial appointments. During the war two Indian lecturers had been appointed to such posts. Among the independent practitioners there were surely many possessing high qualifications who could take up professorial appointments.

If private practitioners were enlisted in a special reserve they would not generally expect any honorarium, but, of course, junior practitioners would expect something if they had to go for a period of military training.

There should be two kinds of reserves formed of independent practitioners; one should be called the "general reserve," and the other the "special reserve." In the general reserve those practitioners should be included who could go to the front, or could take the place of civil officers when they went to the front. In the special reserve those persons should be included who could fill special appointments such as civil surgeoncies, or could be put in charge of jails or lunatic asylums, etc. Practitioners over 45 years of age should not be expected to go abroad, and should be allotted some sort of work at their own stations. Junior practitioners would be quite willing to go to the front.

There were some 18 Punjabis in the Indian Medical Service all of whom belonged to high castes. It would be very difficult for a low-caste man to get into the Indian Medical Service, because of the expenses of education, and because they had to produce a certificate of respectability before getting into the service.

Private practice among Indian Medical Service officers had declined of late years to some extent in big stations, as the number of private practitioners was increasing. There had, however, been no appreciable change in the mufassal.

(General Giffard.) There was something wrong in the way in which private practitioners were approached for service in the war. For instance in the Punjab, if 10 or 20 men were required, the best thing would have been for the Inspector General of Civil Hospitals to address a body of independent private practitioners on the point, and then those who had offered themselves should have been called to the headquarters and talked to. In Lahore the consultation referred to above could have been done by the Inspector-General of Civil Hospitals and this function could be performed by the civil surgeons in the districts, or candidates could be called to headquarters. There had been some defect in the methods employed by Government in securing practitioners. In reply to the question how Government had failed to get the number required, he pointed out that a large number had offered, and the number might have been greater if they had been personally addressed, or if the Inspector-General of Civil Hospitals had taken the trouble of consulting them. The terms offered were quite satisfactory.

In future private practitioners would be prepared and would join the war reserve, the difficulty in the late war being that they were not prepared. If those who had been granted temporary commissions in the war were made permanent it would offer a great inducement to others to join. They could only ask it as a privilege but not as a matter of right.

Independent practitioners claimed it as a matter of right that they should have a share in Government work in civil hospitals, because without such facilities they

21 March 1919.]

Dr. MIRZA YAQUB BEG.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

could not improve themselves. They could not start hospitals of their own and asked Government as a right, to give them facilities in Government institutions. They consider it as much a right to have those facilities as Government servants. He would not go so far as to admit the right of private persons to run railways, but there was no such risk in allowing private practitioners

to have charge of certain patients. Such facilities were allowed to private practitioners in the United Kingdom and other countries. No doubt there was no Government service in those countries, while in India, on the contrary, all civil hospitals were Government institutions and Government should give private practitioners facilities in these institutions until private ones were started.

The Hon'ble MR. G. S. CURTIS, C.S.I., I.C.S., Ordinary Member of Council, Bombay.

Written statement.

I must state at the outset that the Government of Bombay regret that they have been unable to give this very important question the attention which it requires in the very short time at their disposal. Other questions of very great importance have had prior claim and the considered opinion of Government will, therefore, not be forthcoming for some time yet. In order, however, to cause as little inconvenience as possible to the Committee I am attending here under instructions from His Excellency the Governor to place my personal views before the Committee for their consideration. In doing so, I must premise that they are my personal views only, and that other members of this Government may differ from me, but such as they are, they are the views of a layman who has had more than ordinary opportunities of studying this particular question and has tried his best to arrive at a practical conclusion.

2. The main question on which our opinion is asked is the desirability or otherwise of the creation of a unified superior medical service of India both for military and civil duties. I am very strongly of opinion that it is not desirable, and that any attempt to maintain a unified medical service both for civil and military duties will end in failure. My reasons are shortly as follows: At the present moment the civil part of the Indian Medical Service exists purely as a war reserve. As a result of this arrangement on the outbreak of the recent war some 36 out of 44 civil Indian Medical Service officers were swept away from civil work, leaving the medical care of the civil officers of this Presidency and the medical education of some 1,400 students in the hands of eight Indian Medical Service officers. We have now been nearly five years at war and this arrangement still continues, in spite of vigorous protests on our part. I respectfully contend that the whole basis of this arrangement is wrong. It is, I know, necessary to provide an adequate medical staff for the army. But it has been found perfectly possible to recruit over 900 medical men quite competent to perform the class of work required with an army from among the local medical profession. It is a wasteful and intolerable arrangement to remove for periods of years at a time the small staff of highly trained officers, on whose retention the health of the civil administrative staff as well as the supply of trained medical men to fill the gaps in the lower ranks of the subordinate medical services must necessarily depend.

3. As an instance of the inconvenience which this policy may entail I would mention that on mobilization the Government oculist was swept off and placed in charge of a hospital train. As a result there was and is no reliable European oculist left in the Presidency to look after the eyes of civil officers and the Surgeon-General had to summon a retired oculist from Rajputana to treat a High Court Judge and the Chief Secretary. I am credibly informed there were several cases of wounded military officers sent to Bombay whose eyes required attention but could not receive it. Another anomaly which came to my notice was a suggestion in the fourth year of the war from the Director-General of the Indian Medical Service, the effect of which, if adopted, would have been that the whole of the teaching staff of the Grant Medical College would be sent off on service and their places

taken by officers who had been on service, the only reason assigned being that the former had not been on service yet and it was only fair that every doctor should have experience of the rough as well as the smooth. No account seemed to have been taken of the fact that the training and supervision of 900 students require a certain amount of special skill and experience. I am glad to say that the Director-General was good enough not to press this proposal. I would urge very strongly that quite apart from objections of a political nature with which I shall deal later, it must be inexpedient to strip the civil administration of over three-fourths of its medical staff, merely to provide 30 or 35 doctors for the army. Such a proceeding was of course tolerable in old days when a war lasted a year or two and when the local medical profession had not reached its present size. At the present moment it is at once wasteful and unnecessary.

4. I contend therefore that the civil side of the Indian Medical Service as at present constituted must in time cease to exist. The staff required to fill civil medical appointments under Government must be recruited separately without any reference to the necessities of war, and arrangements should be made, when war does break out, to leave them absolutely unaffected. In so far as their duties involve the preservation of the health of the civil administrative staff and the police, the medical care of jails, lunatic asylums and the civil population and above all the education of aspirants for the medical profession, they are engaged in absolutely indispensable work, work which is always important for the maintenance of the civil administration but which becomes essential at a time when civil authorities cannot rely on the military arm for support.

5. I will now proceed to develop my proposals, such as they are, for the future medical arrangements in this country. I start with the assumption that the Indian Medical Service, as at present constituted, must go. I trust in expressing this opinion, I shall not be charged with ingratitude. I have seen more of the work of Indian Medical Service than most men and I have been astonished at the self-sacrifice and devotion to duty invariably displayed in the face of the many disadvantages under which they labour, heavy work, restricted leave, inadequate pay and support. But I am convinced that the time has come when the Indian Medical Service like my own service, will have to change with the times and possibly disappear altogether. First of all as regards civil medical side. Here I must lay down as an axiom that, whatever shape the reform may take, that it is absolutely necessary that there should be a definite European element maintained at a constant figure. My reasons for this view are the following:—

As a layman I am not prepared to lay down whether in point of medical skill a European or an Indian is or is not the better man; and I am not going to discuss the comparative merits of these two classes from an administrative point of view. But there are certain undeniable facts. These are that the Grant Medical College was founded in 1845 and that western medical science has therefore been taught to the Indians for three quarters of a century only. Despite the extraordinary success which has attended the effort of its exponents, I do not think that the 21st century is a

7 March 1919.]

The Hon'ble Mr. G. S. CURTIS.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

long enough time to educate the inhabitants of a country or to affect their attitude towards western medical science. This Presidency is probably as advanced as any other part of India, and yet I am doubtful whether among the most advanced and educated classes there is any genuine confidence in western medical science, in other words, whether in his heart of hearts the ordinary Hindu or Mussalman would not prefer to be treated by an Ayurvedic Vaid or Unani Hakim on his death bed. To put the matter plainly, western medical science is still an exotic even in Bombay and unless it is supported and cherished to some extent by men who are natives of the country where it had its birth, there is, in my opinion, a very great danger lest it should degenerate into a compromise between the practice of modern Europe and that of India in the time of Susrut and other mythical sages.

6. If this danger exists in Bombay, and I have the best reasons for considering that it does, it must surely exist in other provinces. And the recognition of its existence implies the admission that a civil medical service consisting entirely of Indians would in the present stage of public education in this country be impossible. If it is once conceded that the civil Indian Medical Service must have its quota of European officers, it remains to be seen how they are to be recruited. Here my view is that for all posts where special training is necessary officers should be engaged for terms of years. We are proposing to engage a staff for the new institute of tropical science in this way. The Committee of the Royal Society will invite applications from candidates, European and Indian, and make a selection of the best men. I would fill the professional chairs similarly; also the sanitary staff, the alienists and possibly the jails. As regards the staff for ordinary district work a regular civil service would be necessary. Of this a certain percentage should be European and possess certain definite qualifications. This principle has been already accepted by a strong committee which recently dealt with the recruitment of class I of the educational service in this Presidency. A European officer would either draw the same scale of pay as an Indian *plus* an exile allowance or preferably a higher scale of pay altogether. He would of course in the early part of his career serve in some small district; but he might eventually hope to obtain Poona or Karachi or possibly Bombay and have opportunities of private practice.

7. I need hardly observe that a service of this sort must be entirely provincial. The Local Government would fix the number and the pay having regard to the demand and supply of medical men. The Government of India would have nothing whatever to say in the matter, unless from a medical point of view the administration of the Presidency fell below the proper standard or showed defects in sanitary and medical arrangements which required their interference. Of course they would have the right of inspection, examination and in certain conditions re-entry in order to ensure that the administration should be conducted on a proper level but they would not recruit the men and would have no power of interference with appointments. I would respectfully urge that whether "diarchy" is to come or not and whether the medical department is or is not to be a transferred subject it is practically certain that the whole question of medical relief must be a matter which will in a very short time be entrusted to the charge of a minister elected from the Legislative Council. The expansion of institutions for medical relief by a purely Government agency has, in this Presidency at any rate, reached its limit. Any further expansion must be carried out through the agency of local self-governing bodies under the stimulus and, we hope, the strict control of some central agency analogous to the Local Government Board in England. To secure this the civil medical staff must be wholly provincial and wholly under the control of the Local Government. In no other way can the elasticity, which is so essen-

tial to enable the medical department to cope with the epidemics which from time to time ravage this country, be secured.

8. It will, I know, be objected that under these altered conditions it will be impossible to recruit Englishmen for service in this country. I do not agree. It is all a matter of paying a fair wage. The Bombay Municipality engage their own health staff in England. We ourselves frequently engage medical officers to deal with epidemics or for particular objects without any difficulty. Engineers, who like doctors undergo an expensive and specialised training, have for years past been engaged by municipalities, railway companies and so forth for short terms of service in this country.

9. Having outlined somewhat crudely, I am afraid, my proposals as regards the civil medical service, I now turn to the military side. Here I fully admit that with the civil appointments taken away, the Indian Medical Service will cease to attract candidates and that it would be no longer possible to attempt to recruit a medical service (consisting in ordinary time of Europeans to the extent of some 80 per cent.) on anything like the present basis. It seems to me practically certain that the Indian Medical Service must go. What is to become of the army? Here it seems to me that before attacking a problem you must lay down what size your army is going to be. At the present moment I have no idea at all. Assuming, however, that it will number about 150,000 men I would provide for the 450 or 500 medical men required in the following way. I would officer the higher staff posts mainly by officers recruited from the Royal Army Medical Corps as in Egypt and Indian Medical Service. The former would have to be given liberal allowances to induce them to volunteer for Indian service. But I believe the arrangement will be economical in the long run. Then I would reserve a certain proportion of the appointments for Europeans only. These would receive pay of grade *plus* expatriation allowance; they might receive a bonus, say £500, on completing ten years' service. The justification for this reservation would be that already assigned for making a similar reservation in the case of civil medical service, *viz.*, the overpowering necessity of maintaining touch with western medical schools and preserving a high standard of professional etiquette and tradition. It is probable that the scale of remuneration to be given to this class of officers will be higher than that to which we have been accustomed. The balance of the appointments should be thrown over to an open competition by Indians. I am inclined to think that a necessary preliminary for one who enters an examination should be at least one year's study in an English hospital, and I would prefer to hold all examinations in England. All medical officers recruited by examination should be sent to a centre where British regiments are stationed, and do a period of training with a British hospital (if such institutions are to be allowed to continue).

10. As regards the question whether the examination should be held in England or India, I am inclined to think that as the expense of one year's residence in England will not be very serious there will be no hardship in holding the examination in England. In this case scholarships might be granted to promising candidates whose means will not admit of such a sojourn. It might also be considered whether it would not be possible to recruit a number of young Indians as medical officers for terms of 5 or 10 years on the understanding that they should receive a bonus and retire into private life on the expiration of this period. I understand that this has been tried with success in the Royal Navy and might answer here. It would be quite possible to confine recruitment to the civil medical service to candidates who have passed this period in the military department.

11. I am aware that the whole of this proposal of mine will be criticised as it is based on the ground

21 March 1919.]

The Hon'ble Mr. G. S. CURTIS.

[Continued.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

that I fail to make provision for the medical treatment of European officers of Government stationed in small stations. My answer to this is that the state of affairs under my scheme would be no worse than it is at present. At the present time most small stations are in charge of Indian medical practitioners of the assistant surgeon class; it is only in the largest stations such as Ahmedabad, Ahmednagar, Nasik, Poona, Belgaum, Karachi, Hyderabad, that a European officer can rely on obtaining a European doctor for himself and his family. At the same time I would recognise that European staff have a grievance in this respect and I would endeavour to ensure a thoroughly efficient hospital with accommodation for ladies and children at six or more central stations. If necessary, the military hospitals should take in this class of patients. I would also lay down as an ideal to be aimed at that no Indian medical practitioner should be placed in charge of the headquarters of the district unless he has gone through one year's training in an English hospital which should include at least two months in a maternity hospital.

12. In the above paragraphs I have endeavoured to sketch as shortly as I can my idea of general arrangements necessary for medical relief in India. It must in any case be years before they or anything like them can be brought into operation and in the meanwhile there are defects in our existing arrangements which should be our object to remedy as soon as possible. In the first place I would urge that it is necessary to secure closer co-ordination of efforts between the Royal Army Medical Corps on the one hand and the Indian Medical Service, whether military or civil, on the other. A few months ago in Poona there was a very bad influenza epidemic. The civil surgeon almost killed himself in endeavouring to cope with this single handed. There were at that time I believe some 16 or 18 highly qualified medical men attached to the Wanowri station hospital. It should have been possible to depute some of them to help the civil surgeon. We should have been delighted to pay them for their services. But the suggestion was never made. It should, I think, be possible for the Surgeon-General to arrange a periodical conference with the army medical authorities and enlist their assistance when circumstances require, provincial funds paying where necessary. The account rules may make such an arrangement difficult at present. If they do, the accounts are made for men and not men for accounts and the difficulties must be got over. *Vice versa* there are cases in which the military might reasonably demand assistance from the civil department. At the present moment for instance there is a first rate civil hospital in Mahabaleshwar very little used. It could doubtless be used with the greatest advantage for military convalescents from Poona. In the matter of hospital treatment there should, I think, be more give and take between the two services. For instance, I am anxious to abolish the European general hospital in this city as a separate institution and sometime back suggested that it might be possible to arrange that a ward should be added to the military hospital at Colaba,

which would accommodate patients from among the civil residents of that neighbourhood. The latter are largely of the shop-keeper class and use the European general hospital frequently. The then Surgeon-General told me that my suggestion was impracticable. I should be glad to hear that it is not. Another case where concentration of efforts seem possible now, is Satara where there is a small military hospital and a small and bad civil hospital. We shall have to rebuild the civil hospital and we can easily arrange to take over such military patients as may be sent. The doctor in charge is generally a picked military assistant surgeon and the arrangement I am sure would work well. These are two instances of what I would urge should be done generally.

13. It may perhaps be objected that this co-ordination of efforts would be much more feasible if the scheme for the unified service was carried into effect. I admit that there is force in this objection. At the same time even with the unified service the civil branch must be under the control of the provincial government, while the military branch must be under the control of military authorities, in other words, the Government of India, and the possibilities of joint action would be, it would seem, no greater than under a scheme such as that sketched by me.

14. So much for the future constitution of the medical services in India. There remains one point on which I should like to make a few remarks, namely, the medical stores department. The present medical stores are situated on a very valuable site at Byculla and I understand that the military department contemplate erection of a large building there. Our own civil medical stores which are housed in an antiquated building adjoin. I urged sometime ago in conversation with the medical storekeeper that the construction of a new medical stores building on this site is inexpedient and that a more suitable site could be found in the immediate proximity of the docks and Port Trust Railway where stores will be dealt with and despatched without the necessity of a long journey in a bullock cart. A further strong reason for not proceeding with the building at the present moment is that it is practically certain that the Grant Road Station of the Bombay, Baroda and Central India Railway will be very much enlarged and that the site of medical stores would be very useful in that connection.

15. A further question arises in connection with the medical stores department as to whether it is likely to continue permanently on its present footing. I have recently had under consideration somewhat elaborate proposals for fresh legislation in the matter of preventing adulteration of food and drugs. Should these proposals materialise it is possible, I understand, that large firms, such as Burroughs and Wellcome and Parke Davis & Co., will establish branches in this country and contract to supply all drugs and similar articles which the army may require. In this case the necessity for a large central medical stores would probably disappear.

The Hon'ble Mr. CURTIS, called and examined.

(President.) The 900 medical men who were recruited for work with the army during the recent war, and given temporary commissions in the Indian Medical Service were the best that could be obtained, and they were quite competent to perform the class of work required with an army.

The practice of stripping civil administrations of their civil surgeons for army work was tolerable, in the old days, as then wars only lasted for a year or so, but such a course was inexpedient at the present time and it put civil administrations to great inconvenience.

His statement that the practice of western medicine was not making progress even amongst the advanced and educated classes, and that men preferred to be

treated by an Ayurvedic Vaid or Unani Hakim, was based on his personal observations. In recent debates in the Bombay Legislative Council the speeches of all the non-official Indian members indicated that they themselves still held to the old system rather than the western system of medicine.

Two lakhs of rupees have been allotted for the erection of an institute of tropical medicine in Bombay and work has commenced on it.

He had not anticipated much difficulty in recruiting Englishmen for his civil medical service in the altered conditions suggested by him, if the pay offered were attractive. Business firms were at present offering

20 March 1919.]

The Hon'ble Mr. G. S. CURTIS.

[Concluded.]

(The schemes and questions referred to by witnesses are contained in Volume III.)

liberal pay to Europeans and, in fact, they were trying to bribe Government servants to join them.

(General Hendley.) He was in favour of the introduction of legislation to prevent the adulteration of drugs. In the absence of such legislation he considered that Government medical store depots served a valuable purpose in assuring the supply of unadulterated drugs.

He considered it a wasteful and intolerable arrangement to remove highly trained civil officers for military duty in case of war, as he was of opinion that these officers were practically on active service where they were. By the removal of these officers the civil administration had greatly suffered. He was not qualified to say whether the assistant surgeons who had taken the place of civil surgeons had performed their duties satisfactorily or not.

There would be no objection to good junior officers who had already seen field service taking the place of the senior officers in order to give the latter an opportunity to proceed on military duty, if they so desired.

The civil medical service proposed by him would be entirely provincial, and the local government would fix the cadre and the pay, having regard to the demand and supply of medical men. The Government of India would have nothing to do with this service, unless from a medical point of view the provincial administration fell below a proper standard, and showed defects in the sanitary and medical arrangements, which required their interference. The Government of India would, of course, always have the right of inspection of the management of the provincial administration. His proposal was really based on the assumption

that there would in the future be an elected member in charge of the medical department.

The Government of Bombay had just appointed a Royal Army Medical Corps officer as assistant health officer in Bombay. In the event of his leaving they always had an understudy to take his place.

For district work a regular civil service would be necessary, and for this he would recruit a certain percentage of Europeans, who would during the early part of their career serve in small districts. These officers might eventually hope to obtain appointments at Bombay or Poona and have opportunities of private practice.

(General Giffard.) When asked whether any appointments in the civil medical service which he contemplated would be given to officers forming the war reserve of the army, he replied that this would depend on the manner in which the new service was to be worked.

In addition to the provincial civil medical services he would have a certain number of appointments on a general cadre, which would probably include sanitary officers, health officers and medical men employed by municipalities and local boards. He thought that they should all be borne on one cadre in order to ensure regularity of promotion.

He was also in favour of pooling all the professorships of the colleges on an Imperial cadre. For certain special professorial appointments he would recruit his officers on special short terms of agreement.

He advised that the civil and military should work hand in hand as much as possible, and that in each station there should be a joint board of health to look after both the civil and military areas of the station.

MEMORANDA SUBMITTED BY CO-OPTED MEMBERS OF THE MEDICAL SERVICES COMMITTEE.

	PAGES.
Sir TEMULJI B. NARIMAN, Kt., Bombay	324
Lieutenant-Colonel BHOLA NATH, C.I.E., I.M.S.	326

COMMUNICATIONS RECEIVED FROM LOCAL GOVERNMENTS, AND VARIOUS BODIES AND INDIVIDUALS WHOSE ORAL EVIDENCE WAS NOT TAKEN BY THE COMMITTEE.

Letter No. 1044-Medl., dated the 29th March, 1919, from the Secretary to the Government of Bengal, Finance Department, to the Secretary, Medical Services Committee	330
Letter No. 80-M—5-X-3, dated the 20th March, 1919, from the Secretary to the Government of Burma, to the Secretary, Medical Services Committee	334
Letter No. 475—5-X-4, dated the 13th February, 1918, from the Secretary to the Government of Burma, to the Secretary to the Government of India, Home Department	340
Letter No. 89-M. T., dated the 26th February, 1919, from the Secretary to the Government of Bihar and Orissa, Municipal Department, Medical Branch, to the Secretary, Medical Services Committee	343
Letter No. 1633-M. T., dated the 30th March, 1919, from the Secretary to the Government of Bihar and Orissa, Municipal Department, Medical Branch, to the Secretary, Medical Services Committee	344
Letter No. 9-E—19, dated the 14th February, 1919, from the Secretary to the Government of India, Railway Department (Railway Board), to the Secretary, Medical Services Committee	347
Letter No. 1668, dated the 15th March 1919, from the Secretary, European Association, to the Secretary, Medical Services Committee	348
Letter No. 1003—1919, dated the 19th March, 1919, from the Secretary, Bengal Chamber of Commerce, Calcutta, to the Secretary, Medical Services Committee	349
Letter No. 115 of 1919, dated the 28th February, 1919, from the Honorary Secretary, Bengal National Chamber of Commerce, Calcutta	349
Letter No. 310—85-M., dated the 14th March, 1919, from the Secretary, Chamber of Commerce, Bombay, to the Secretary, Medical Services Committee	349
Letter, dated the 18th March, 1919, from the Secretary, Indian Merchants' Chamber and Bureau, Bombay, to the Secretary, Medical Services Committee	350
Letter, dated the 20th March, 1919, from the Secretary, Indian Association, Calcutta, to the Secretary, Medical Services Committee	351
Memorandum, dated the 21st March, 1919, by the Delhi Medical Association	351
Letter No. 4736, dated the 19th March, 1919, from the Principal, Medical College, Madras, to the Secretary, Medical Services Committee	355
Memorandum, dated the 2nd March, 1919, by Lieutenant-Colonel E. D. W. GREIG, C.I.E., I.M.S.	355
Memorandum, dated the 12th March, 1919, by Dr. S. N. TIWARI, officiating Sanitary Commissioner, Bihar and Orissa	356
Memorandum, dated the 13th March, 1919, by Lieutenant-Colonel F. H. G. HUTCHINSON, M.B., I.M.S., Sanitary Commissioner, Bombay	357
Memorandum, dated the 8th April, 1919, by Lieutenant-Colonel W. F. HARVEY, M.B., I.M.S., Director, Central Research Institute, Kasauli	362
Memorandum, dated the 15th April, 1919, by D. A. TURKHUDD, M.B., C.M. (Edin.), officiating Assistant Director, Bombay Bacteriological Laboratory, Parel, Bombay	365
Memorandum, dated the 4th April, 1919, by Miss A. M. WATERHOUSE, R.R.C., Chief Lady Superintendent, Queen Alexandra's Military Nursing Service for India	367
Memorandum, dated the 25th March, 1919, by Dr. M. I. BALFOUR, M.B., Women's Medical Service, Joint Secretary, National Association for Supplying Female Medical Aid to the Women of India	368
Note on the re-organization of the Indian Medical Services, dated the 3rd March, 1919, by Sir F. G. SLY, K.C.S.I.	369
Memorandum, dated the 20th February, 1919, by temporary Colonel W. H. WILLCOX, C.B., C.M.G., Army Medical Service	370
Letter, dated the 20th February, 1919, from the General Secretary, Bihar Planters' Association Ltd., Muzaffarpur	372
Letter, dated the 25th February, 1919, from the Secretary, United Planters' Association of Southern India, Coimbatore	372
Letter, dated the 22nd February, 1919, from the Managing Agents, the Howrah-Amta Light Railway Company, Ltd., Calcutta	372
Letter No. D. H.-132—1, dated the 27th February, 1919, from the Agents, Darjeeling-Himalayan Railway Company, Ltd., Calcutta	372
Letter, dated the 6th February, 1919, from the Secretary, Cambridge Mission, Delhi	373

	PAGES.
Letter, dated the 10th February, 1919, from the Secretary, Church Missionary Society in the Punjab, North-West Frontier Province and Sindh, Lahore	373
Letter No. 237, dated the 19th February, 1919, from the Secretary, Society for the Propagation of the Gospel in Foreign Parts, Madras Diocesan Committee, Madras	373
Letter, dated the 24th February, 1919, from the General Superintendent, Wesleyan Mission, Bengal, Calcutta	373
Letter, dated the 28th February, 1919, from the Secretary, Society for the Propagation of the Gospel in Foreign Parts, Ranchi (Bihar and Orissa)	374
Letter, dated the 11th April, 1919, from the Secretary, Darjeeling Planters' Association, Darjeeling .	374
Letter No. 460—O., dated the 22nd April, 1919, from the Secretary, Indian Tea Association, Calcutta .	374
A paper on the promotion of hygiene and the prevention of malaria and other diseases by co-operation by the Hon'ble P. C. MITTER, C.I.E.	374

Memorandum submitted by Temulji Nariman, on the 22nd March, 1919, before leaving the Committee.

In the first place I must thank the Government of India and the Bombay Government for giving me an opportunity to serve on the Medical Services Committee during their visit to Calcutta, Madras and Bombay. I, however, understand from what the President of the Medical Services Committee told me, that the scope of my usefulness is extremely limited, as I have neither a share in the drafting of the report nor in the signing of it. I really do not know the object of co-opting me on the Committee as I can be of no use in helping Government to come to the right conclusion, and though I am told that my report is not necessary, I think it best to express my opinion on the subject of inquiry. The experience and the knowledge gained by reading the written statements of the different witnesses, hearing their evidence and examining them on different points, particularly as they embodied the views of people from all parts of India, including Burma and Assam, have enabled me to lay out my views for the benefit of the President and the Members of the Committee.

I must at once confess that the knowledge and the experience gained have considerably widened my angle of vision, and I think the time has arrived when in fairness and justice to the Indian medical graduates, they ought to be given a much larger share in the civil and military medical administration of India. We had a large array of distinguished Indian Medical Service officers, the Director-General, the Surgeons-General, the Principals of the different medical colleges, and other military officers and officers of the Indian Medical Service and Royal Army Medical Corps, expressing their opinion as to the inefficiency and incapacity of the Indian medical graduates and the subordinate Government medical staff in their present stage to hold professorial appointments in teaching institutions, and administrative posts held at present by the members of the Indian Medical Service, even though they may be possessing British qualifications and British degrees of the highest order, and even training in British institutions, on the assumption that there is something inherent in them, and in their home training, which incapacitates them from holding such posts or offices, and that they have not the same grasp as the average British officers. They say that it is not in professional matters alone that the education received in the United Kingdom is advantageous, but the student who has enjoyed the British education has had at least the opportunity of assimilating western ideals of professional, social and moral conduct. Though in their official reports these high officials have expressed their satisfaction at the work done by Indians during the war, when most of the administrative posts in their occupation were filled by Indians, in their written statements and in their examination they have expressed it as their deliberate opinion that the work of most of the Indians was not satisfactory, and that there was laxity in their discipline and control. They no doubt admit that a small percentage did their work satisfactorily but that a much larger number did not come up to their expectation. All the Indian witnesses on the other hand quoted some of these official reports and expressed their deliberate opinion, that the work done by the Indians in all possible positions, both military and civil, has been spoken of, with few exceptions, in high terms by the highest possible authorities. One of the Indian witnesses said that fortunately for the Indian medical man, his patriotism, his manliness and his eager desire to do his duty, have been subjected to a very great searching test, and he has come out of the crucible of the greatest war in history quite unscathed and with flying colours. He said that reports to hand from all quarters show that the civil assistant surgeons who had largely replaced the Indian Medical Service officers had acquitted themselves in a manner which has surprised friends and confounded foes.

The Government of Madras in their review of the report of 1916, dated 24th September, 1917, said "that the hospitals both in Madras and in the mofussil have been short handed, but have been kept going by the exertions of the officers in charge

(mostly Indians) and the number of patients treated and the number of operations performed have been larger than ever before, while the death rate has been lowered."

I can only come to one conclusion: that there are exaggerations on both sides. Even if we admit that the assistant surgeons and the temporary commissioned officers did not come up to expectations, we must admit that they had never had the opportunity of direct personal responsibility for medical work. Numbers of Indian medical officers who have never been obliged or even permitted to undertake really responsible duties apart from close supervision by British officers, have suddenly had the whole burden of institutions, and the medical care of towns and districts thrust upon them. They have had to do operations and treat serious cases, such as they would never have attempted single-handed before. In some cases doubtless this has meant failure, but I believe, it is the barest justice to add that a very large proportion of such Indian medical officers, have shouldered their burdens bravely and wisely, and will be found later on to have become far more capable and efficient as a result. This is the independent testimony of Dr. Lankester, whose opinion on the increased prevalence of tuberculosis in some of the jails was quoted by some of the witnesses to prove the administrative incapacity or inefficiency of Indian medical officers in charge of jails during the temporary absence of Indian Medical Service officers.

As I stated above there are exaggerations on both sides. I contemplated writing out my views at leisure after perusing some of the statements, but as the President on the last day of the sitting after finishing the work asked me to give a memorandum of my views, I find there is no time left and that I should briefly express the conclusions I have arrived at. As I say, I had no time to study the whole question as I was busy up to the last day.

Not one of the schemes recommended by the Committee was acceptable to the majority of witnesses; they all preferred one scheme or other with considerable modifications. In the first place the Indian Medical Service and Royal Army Medical Corps officers had shown considerable disagreement among themselves, and the Indian Medical Service officers complained of the jealousy of the Royal Army Medical Corps officers.

There are considerable difficulties in the way of unifying the two services. If the Royal Army Medical Corps and the Indian Medical Service are converted into a unified Indian Medical Corps the great difficulty arises about the incorporation of the Indian Medical Service officers in one corps.

The European witnesses one and all were not in favour of the treatment of British soldiers by the Indian officers of the Indian Medical Service, and suggested that, if that was done, there would be considerable difficulty in the recruitment of British soldiers, though the Madras Government in their statement did not anticipate such difficulty. Another objection was that the British medical officers in a station hospital where both British and Indian soldiers are treated, would not like to be subordinate to the Indian Medical Service officer if he was senior and in charge. Colonel Bhola Nath gave his experience in Mesopotamia where there were many such officers under him who did not complain about it. It is quite possible that the great war had for the time united them all. If Indian officers of the Indian Medical Service are to treat Indian soldiers only, and British medical officers to treat both British and Indian, an invidious distinction is made, which the Indian officers will naturally resent. In fact a racial question will be raised which it will be difficult to solve.

In Calcutta all the European witnesses complained of the inefficiency in midwifery training, and recommended a course in midwifery in England before the Indian candidate appeared for the Indian Medical Service Entrance Examination. The Principals of the Madras and Bombay Colleges on the other hand thought that there was ample scope and material for

midwifery work in their Presidencies, and that the medical education of their graduates was as good as that imparted in British institutions, and that, if a separate examination for the Indian Medical Service was held in India, the successful candidates need not be asked to waste their time in obtaining British diplomas, but to occupy that time in gaining insight into British social life and working as house surgeons or house physicians in London hospitals.

The Indian witnesses demand fifty per cent. of all appointments, while the British witnesses suggest from ten to twenty-five per cent.

The conclusion to which I have come is that no changes should be made till we hear the final decision of the British Parliament on the Montagu-Chelmsford Reforms Scheme, and of the action of those in authority on the recommendations of the Public Services Commission, as our recommendations in this report will be valueless, if the home authorities insist on a large number of Indians being recruited into the medical services, and recommend the separation of the military from purely civil medical service, and insist on a simultaneous examination to be held in England and India. It is clear that in the present state of the country, with all its political and other activities, the claims of Indians for a larger share in the administration of the country must be satisfied, and if such claims are conceded in the case of all other services, I cannot understand why the medical profession in India should be debarred from enjoying higher privileges. If we find Indians filling the posts of High Court Judges and even those of Chief Justices of High Courts, and when they are given control and charges of administration as members of the Imperial and Provincial Executive Councils, and when an Indian is found fit to take up the post of Under Secretary of State for India, no sane man can deny that an Indian medical man is as fit to fill a medical administrative post as other Indians are to fill administrative posts in other lines. The education they receive is the same for all professions. If it is faulty in medicine, it is faulty in arts and science, so that the disqualifications on account of educational culture will be the same for all. I fully admit that at present at least two years' training in social and medical education is essential after completing a full course of medical study in India, and for the Indian Medical Service, it may be insisted upon, but for other civil medical services, the posts can be filled by Indian graduates. As they are not given opportunities and facilities for independent charges they may not be found efficient for a year or two, but once they are given responsible posts, I am sure, they will be found capable of shouldering their burdens. The Indians lag behind simply because they are not given opportunities and facilities to hold responsible posts. I must admit that India is a vast continent, and from what I saw and read and heard, during my attendance on the Committee in different places, it became glaringly evident that the mental, moral, and physical conditions of the people vary considerably in different presidencies and provinces and the standard of fitness for administrative and responsible posts must necessarily vary, and for some years to come you may not find capable candidates for certain posts in some places. I think therefore that the capital cities of Calcutta, Madras, and Bombay ought to be treated more liberally than some of the other backward provinces, and larger numbers of civil and military appointments thrown open to deserving aspirants. In the course of a few more years the backward provinces may claim greater shares and they may be treated according to their fitness.

I would suggest that the Royal Army Medical Corps should be kept distinct as at present, and that the Indian Medical Service be also kept as it is. The grievances of the latter service for leave and allowances and other matters may be remedied but I would not increase its cadre. Some of the appointments held by these officers may be thrown open to Indian graduates and if Indian Medical Service officers are thus relieved of those posts, there will be a reserve for sickness and leave.

I would also suggest that a separate civil medical service be created, or the present assistant surgeon class be improved, and recruited by competitive

examination and the condition of military training enforced. This class will form a good war reserve and during the time of emergency, as in the present war, independent private practitioners can be enrolled. If paid they will come in any number and will prove of great service. It is no use keeping a superfluous and very large reserve for a very remote and unlikely contingency.

The pay and prospects of the civil assistant surgeon class should be improved considerably. There ought to be two grades of this service one rising from Rs. 200 to Rs. 450 or Rs. 500 and the other rising from Rs. 500 to Rs. 1,000 or Rs. 1,200. Promotion from the lower to the higher grade should be open to a limited number after ten years' service, by selection or nomination. The higher grades should fill up posts taken from the Indian Medical Service cadre; jails, sanitation and even education can be entrusted to this branch. You can fix up your own standard for qualification for these posts. Unless you test them by giving them responsible posts, you will not be able to judge of their fitness or otherwise.

We have the testimony of one class of witnesses that they were found unfit; we have also the testimony of another class of witnesses and the reports of the different Governments that they filled the posts to their satisfaction. One thing must be acknowledged: that the assistant surgeon class for the last many years was filled by second class candidates, and that those in the first class, or rather the better class, of Indian graduates did not care to join the service as the prospects and emoluments were not satisfactory. With a competitive examination and the improved prospects we will be able to secure the cream of the medical profession.

As for the professorial appointments, the consensus of opinion of the British witnesses was for the posts to be filled up by Indian Medical Service officers, and that of the Indians was for their being thrown open to all, independent of caste, creed or country, that is, to appoint the best man wherever found. A great mistake was made in former years in filling up such appointments. I will be satisfied, if a large number of Indian Medical Service officers are chosen from the best men in the whole service, and there must be an Advisory Board, consisting of three European and one Indian of position and independence, for the selection of the right sort of candidate for the particular post, and some of the senior chairs must be thrown open to Indians, as is done in Bombay, but they too must be filled by men of the highest qualifications and not, as is done now, by nomination by a professor or principal of the college. In fact the same board should select these candidates.

In Bombay we shall soon have a medical college and the King Edward's Hospital to be officered by Indian graduates and maintained by the Bombay Municipality. If the Government College, I mean the Grant Medical College, is properly staffed by Indian Medical Service officers, there will be a healthy rivalry, which will benefit both science and humanity. In Calcutta too there is the Belgachia College, to which the Government of Bengal has given an endowment of five lacs and a recurring grant of fifty thousand rupees. Madras may follow suit, and we can then have field for work for both Indian Medical Service officers and independent medical graduates.

Posts of honorary surgeons and physicians and assistant honorary surgeons and physicians should be created in other places as is done in Bombay and the period of tenancy should be limited to three, or at most five years.

The military assistant surgeon class should be abolished and all civil posts held by them be thrown open to members of the civil service of the two grades which I have suggested.

Most of the witnesses were in favour of abolishing this class, as their education both preliminary and professional is inferior to that of the civil assistant surgeon class, and in the hospitals for British soldiers where they are employed they do the work of clerks, dressers, and quartermasters, which can be easily done by laymen.

The sub-assistant surgeon class should be retained as for many years you will require men to work in

the distant villages and small towns. Their education may be a little improved and their pay a little increased but they must distinctly understand when they join the service that their pay and prospects are limited and that if they aspire for higher grades, they must join the medical colleges.

Before I conclude I must declare my emphatic opinion that for the proper administration and for

the safety of the millions of Indian inhabitants a fairly large British element in the service is absolutely necessary, and that for years to come, if the Government do not keep control over all branches of administration, there will be chaos in the country and the benefits of British rule which we have so long enjoyed will be lost to India.

Memorandum regarding the scheme of reforms for the Medical Services in India, submitted by Lieutenant-Colonel Bhola Nath, C.I.E., I.M.S., on the 23rd February, 1919, before joining the Committee.

General considerations.

On a general glance at the schemes* a few points are noticeable :—

1. They all recognise that defects in the service exist which should be put right, but they do not attempt to define what those defects are. If this had been done, there is no doubt, there would be no difficulty in finding a remedy.

2. A conception seems to run through them all that the State has an obligation to provide medical aid to the civil and military population. This may be true, but the further assumption that the claims of the military come before those of the civil population is perhaps open to doubt. This is specially noticeable in schemes B and C.

The main issue, I take it, is the reform of the Indian Medical Service which is a military service. By the unification of the services is therefore to be understood, the union of Royal Army Medical Corps and Indian Medical Service. Viewed from this point the civil side appears to have been dragged in as a side issue.

3. Undue stress appears to have been laid on the question of reserves. Indeed the schemes seem to labour under the fear that no proposal would be accepted unless it provides for reserves. In this anxiety the experience of the present war seems to have been overlooked. The Royal Army Medical Corps had little reserves when they went to war and what they had was soon used up within the first few weeks. It then called for volunteers, but, notwithstanding the proverbial patriotism of the Englishman and the clash and din of arms in his very ears, sufficient numbers were not forthcoming. The service had then to ask for conscription and the raising of the age limit and, over and above this, help had to come all the way from America and the Colonies. By these means the Royal Army Medical Corps was able to draw upon the skill and the organising power of the profession in the whole Empire.

This experience teaches us that no forethought could foresee the extent of a call on reserves. It further shows that the supply of reserves can be relied upon, when the demand has behind it the power of the State to enforce military duty from every citizen. Furthermore it proves that a civilian practitioner can become an efficient military medical man in a few weeks' training. The experience of the temporary Indian Medical Service also shows that a permanent reserve is unnecessary.

4. There is a good deal of common ground in all the schemes which may be taken as universally acceptable, such being, giving the Indian Medical Service :— (1) station hospital system, (2) staff college, (3) increase in cadre, (4) its own corps, (5) improvement in scale of pay and pension, (6) leave rules, (7) promotion, (8) the requiring of European standard of qualification from candidates both European and Indian, (9) the abolition of territorial allotment, and (10) the reversion of officers from civil for A. D. M. S. appointments.

5. On the question of unification of the services they all agree with regard to its desirability, but differ in the method as to how it should be brought about. There are naturally two schools—

Scheme A proposes to absorb the Indian Medical Service into the Royal Army Medical Corps.

Schemes B, C and D propose to absorb the Royal Army Medical Corps into the Indian Medical Service.

Further, schemes B and C retain one Indian Medical Service for the civil and military sides, while D creates a separate Indian civil medical service.

Defects in the Indian Medical Service.

Major—

(a) Organization—

1. Regimental system—

- (i) gives no scope for scientific or professional work;
- (ii) gives no opportunity for administrative training;
- (iii) is abandoned when mobilization is ordered;
- (iv) is wasteful in the employment of medical personnel.

2. Personnel—

The only personnel the Indian Medical Service possesses is the commissioned officer and the sub-assistant surgeon. Its ward orderly, sweeper and bhisti are regimental. On mobilization being ordered the Indian Medical Service sets about to enlist its personnel from the civil population. The personnel thus raised in a hurry possesses no training, cohesion or discipline.

This defect may be sub-divided:—

- Not sufficient . . . Commissioned officers and sub-assistant surgeons.
- Not existing . . . Nursing sisters, quartermasters, warrant officers and men trained as dispensers, clerks, store-keepers, nursing orderlies or enlisted as cooks, bhisties, dhobies, tailors and carpenters.
- Not up-to-date . . . Equipment, medical, surgical, pathological, X-Ray, clothing and transport.

System of check and account.

3. Reserves—

(a) Medical officers and sub-assistant surgeons: At present these are employed in the civil department. Viewed in the light of our experience in the present war, this is unsatisfactory.

In the ease and comfort of civil life the officer soon forgets that he belongs to a military service. He makes himself a comfortable home and a private practice, the separation from which he regards as a hardship and financial loss.

I have heard it argued on several occasions that, when men of the Indian Civil Service go to military duty, they take good care that they do not lose anything by it; then why should we? It is forgotten, however, that the one is essentially a civil and the other a military service. Officers in this frame of mind are not fit for military duty.

Owing to this reluctance on the part of the civil Indian Medical Service officers we find that many of them are retained on inadequate grounds of health or expediency. Residuary and indispensable appointments also exist to keep military men back from military duty. It may also conceivably happen that men who are not in favour are sent out without reference to their fitness or otherwise for military duty. The entertainment of such a large number of temporary Indian Medical Service officers appears to me to have some bearing on this point.

After the officer has done military duty for a year or eighteen months, he longs to go back to his armchair. I have no figures, but it would be interesting if the following figures were available :—

- 1. Number of Indian Medical Service in civil employ before the war.
- 2. Number of Indian Medical Service retained physically unfit.

3. Number of Indian Medical Service retained as residuum.
4. Number of Indian Medical Service returned to civil within twelve months from military duty.

When the officer goes to military duty he requires—and he gets it—preferential treatment. He expects the comfortable charge of a hospitalship, a general hospital or an A. D. M. S. appointment, and we see the spectacle of military Indian Medical Service men being left behind to mind the cantonments, and the civil officers proceeding to France, Egypt and Mesopotamia in command of military hospitals and other formations. Instead of the reserves being used to feed the wastage and casualties of the first line, they take the place of the first line.

In connection with the enquiry into hospital economy I had occasion to visit medical formations in Force "D" in the year 1917-18. Out of the seven general hospitals at the base $5\frac{1}{2}$ were commanded by civil and $1\frac{1}{2}$ by military officers of the Indian Medical Service. On the line of communications out of four Indian general hospitals, three by civil and one by military, and one British general hospital in addition. Of the three stationary hospitals in the Force, two were in charge of the civil and one of the military. The casualty clearing hospitals and the field ambulances had similar proportions. The hospital ships were I believe mostly commanded by civil Indian Medical Service men. This state of affairs is unsatisfactory both from the point of view of efficiency and of contentment on the military side. The advocate of this system of keeping the reserves in the civil might argue that it is not the fault of the machine but of the hands that work the machine. The answer to that is that so long as the inert machine is at the mercy of manipulation by human hands, the human factor cannot be eliminated from our calculations.

Besides, the system being unsatisfactory on the military side, it must cause inconvenience and dislocation on the civil side by withdrawing a large number of officers at one time.

(b) Reserves of other subordinates and menial personnel don't exist.

4. Want of a Staff College.

5. Sources of friction between the Royal Army Medical Corps and Indian Medical Service.

The Indian Medical Service is a tropical service. Its members live and work throughout their service in uncongenial surroundings. This necessitates their periodic visits to Europe for the sake of health or professional improvement.

To enable the officers to meet these expenses and to keep the service attractive to a good stamp of recruits certain inducements are held out. The transfer to the civil department, with prospects of professional work and private practice, being one, and certain collateral charges in the military, being another. These privileges are regarded by the service as its right and any division or curtailment thereof constitutes a grievance. The Royal Army Medical Corps on the other hand is purely a military service intended to serve with British troops in all parts of the British Empire, including India. It is therefore no hardship on the Royal Army Medical Corps to serve in India. As compared to the Indian Medical Service, the Royal Army Medical Corps enjoys certain advantages:—

(1) Their sojourn in India is short and they have not more than two Indian tours.

(2) Even in India it enjoys the benefit of cool and salubrious stations.

(3) On expiration of Indian tour the officer goes home to England at the expense of the State. He need take no leave nor incur any expenses for the benefit of his health or professional improvement.

(4) Rank for rank he draws better pay (A. R., I., Vol. I, para. 155 (d)). With these natural advantages in his favour the R. A. M. C. officer takes his share of:—

(i) Certain collateral charges in the military such as cantonment hospitals, staff surgeon, D. A. D. M. S., mobilisation and sanitary, specialist appointments, etc.

(ii) D. M. S. in India is specially reserved for him.

(iii) A. D. M. S. Division and Brigade and Surgeons-General are divided.

(iv) This process of attrition denudes the Indian Medical Service of a good deal of its attraction and robs the military of a number of senior officers. For this reason, in most stations the senior medical officer is invariably an officer of the R. A. M. C. and any opportunity of administration, the position of senior medical officer may offer, falls to his share.

The collateral charge appointments are made by the A. D. M. S. on the recommendation of the S. M. O.

These causes have given rise to a general impression that the R. A. M. C. dominates and overshadows the sister service.

Complaints are often made by Indian Medical Service officers who have served in this war under the R. A. M. C. administration that they do not receive their due share of honours and decorations, and they attribute this to service jealousy. In Force "D" which was composed mostly of Indian troops and Indian formations, the majority of staff and administrative appointments were held by the R. A. M. C. I believe, there were not more than three A. D. M. S. appointments in the hands of the Indian Medical Service in the whole force.

6. Colour Bar.

1. *Admission.*—It cannot be denied that a colour bar exists and is maintained in the service. The unfortunate expression European recruitment in the reform report has come to mean with a large number of service men the recruitment of Europeans only (para. 23, scheme B), and not that it means the recruitment in Europe of European and Indian medical men.

I yield to none in holding that the high standard of social and professional prestige of the service should be maintained. But I utterly repudiate the suggestion, that it can be maintained only by the European element in the service. The prevalence of such notions and the currency of such catch phrases as "the East is East and the West is West," have widened the gulf between the two communities. This has resulted in the practical exclusion of Indians from the service, with the exception of a very small fraction. The present proportion of Indians in the service is under 10 per cent. of the total strength.

2. *Appointments.*—This colour bar not only stands in our way on admission into the service, but it pursues us throughout our service career.

The following appointments are open to the Indian Medical Service:—

In the military department.

D. M. S. in India and staff, D. D. M. S. and A. D. M. S. Division and Brigade, D. A. D. M. S., Sanitary and Mobilization, Staff Surgeon.

On field service D. M. S. Force and staff, D. D. M. S., A. D. M. S. Brigade and Division, D. A. D. M. S., command of general and stationary hospitals and clearing stations and field ambulances.

In the civil department.

D. G., I. M. S. and staff, Sanitary Commissioner, Surgeon-General with Local Government, Inspector-General of Civil Hospitals, Inspector-General of Prisons, Bacteriological, X-Ray, Chemical Examiners, Medical Stores, chairs in colleges, Assay-master, Naturalist, Political and Foreign Office, civil surgeon of stations like Lahore, Lucknow Delhi, Cawnpore, etc.

With the exception of one Inspector-General of Civil Hospitals and one Inspector-General of Prisons and one O. C. general hospital, not one of these appointments has ever fallen to the lot of an Indian. It cannot be maintained that during the 50 odd years of the existence of the Indian Medical Service there has been no Indian fit to hold these appointments. Nor can it be denied that the Indians have proved their fitness wherever they have been given a fair chance and in whatever they have been called upon to do.

3. *Promotion.*—It has been seriously argued in certain quarters that the higher posts are not given to Indians because Englishmen would object to serve under them. This is a libel on service discipline. Superior authority, whether vested in brown skin or white skin, is alone obeyed and not the skin. I speak on this point from experience. I have had the privilege of commanding a general hospital. I have officiated as A. D.

M. S. on several occasions; I have presided over an important committee of enquiry, but I cannot recall a single instance of friction or unpleasantness with my European friends. I therefore can conceive of no greater wrong than that an officer who has given the best years of his life to the service of the State and has served it well and to the best of his ability, should be debarred from promotion because of the colour of his skin.

4. *Social*.—This colour bar places a mark of invidiousness on its unhappy victim, which affects his social relations with the circle in which he is expected to move.

5. *Exchange compensation*.—A monthly allowance is given to officers as compensation for loss of exchange, which they might incur in making remittances to England. But the Indians are excluded from this privilege. I have been sending money to England for the education of my children for the last 13 years. I have represented my case several times, but have been told that the Government regulations do not allow it. They have placed a bar between the Indians and Europeans. This invidious distinction has no justification either on grounds of equity or policy.

6. *Temporary Indian Medical Service*.—All schemes studiously leave out the claims of the temporary Indian Medical Service men. Surely they must know that some of these men have done good work and have earned honors and decorations. Many of them possess British qualifications. To leave out the claims of men who have borne the heat and burden of the day since the beginning of the war and to suggest the promotion of military assistant surgeons is hardly fair (Schemes B and C).

7. *Doors shut*.—The committee is aware that increasing numbers of Indian young men go to Europe for education every year. On return to their native land, they find that avenues to an honourable career in the public services are blocked. If this state of things is to continue and if the colour bar is to remain, I for one would be glad to see the doors completely shut.

8. *Appeal*.—With the growing needs of the country and with the extension of education there is increased demand for employment. I therefore appeal to the committee in the name of justice and fair-play to recommend that this colour bar, this cruel obstruction in the path of Indian progress be removed not in theory and pious hopes, but in actual practice, so that our sons may be given a larger share of responsibility in the public services of their own country.

Minor—

(a) *Leave*.—A number of furloughs out of India is allotted to divisional areas where a roster is kept, based on the length of service an officer has been without leave. The numbers allotted are insufficient. In the Poona Area in the year 1910 there were 39 officers on the roster and 4 leave allotments. In an Indian infantry regiment, 5 officers may be absent on leave out of a strength of 12 British officers. Owing to frequency of transfers from one area to another the leave roster does not always work equitably.

(b) *Promotion*.—(1) The number of appointments on the list of selected lieutenant-colonels and colonels is small.

(2) Officers revert from the civil side and claim A. D. M. S. appointments.

(3) An officer within six months of completing his term of 30 years' service, receives promotion and a new lease of life to block promotion.

(c) *Pay and pensions*.—Inadequate.

(d) *The Director-General, Indian Medical Service*, who is the head of the service lives remote and does not come in contact with men of his service.

(e) *Allotment by areas*.

(f) *Defective Indian training in European social matters and practical work*.

(g) *Want of consultants*.

(h) *Too frequent and erratic transfers*.

Schemes tested.

Having considered the defects in the service we are in a position to judge how far each scheme is calculated to rectify those defects.

Scheme A.

Leaving aside the considerations of sentiment and tradition to which the Indian Medical Service is undoubtedly entitled, this scheme is open to the following objections:—

(1) By making the Indian Medical Service auxiliary to the Royal Army Medical Corps, it will perpetuate and intensify the sources of friction. Instead of giving anything back, which it has taken from the military side it threatens to encroach upon the civil side also.

(2) By subordinating the Indian Medical Service it will lower its prestige and consequently make it less attractive to good class recruits.

(3) Owing to the difficulty of assimilating the Indian element it is not difficult to conceive of the auxiliary service degenerating into a purely Indian service which is undesirable at present.

(4) The difficulty the R. A. M. C. officer will have in dealing with the Indian troops owing to differences of caste, language and race. The term of their Indian tour is too short to study these questions.

Scheme B.

Is open to following objections:—

(1) It is a compromise and not a true unification; it therefore retains elements of friction. It gives no corps and consequently no personnel beyond suggesting an increase in the medical officers.

(2) It suggests a diminution in the chances of Indians gaining admission and is calculated to maintain and intensify the colour bar.

The scheme views with disfavour the creation of a separate civil medical service. After quoting from Mr. Chaubal's minute of dissent the scheme proceeds to state that the fact of 800 temporary I. M. S. serving in the army proves as nothing else can prove the need of the increase of strength on the civil side. But according to the author it does not prove the desirability of creating a separate civil medical service. The real reason of this disfavour is, however, revealed in para. 22, and is emphasised further by a quotation in italics from the Constitutional Reforms Report. It is not necessary to take further note of this, beyond referring the committee to my opening remarks on the colour bar question. The suggestion is made that European ladies object to being treated by Indian officers of the Indian Medical Service. Presumably the suggestion is based on experience; all I can say is that my experience does not endorse it. I have 26 years' service and all this time I have lived and moved among Europeans of the civil and military services. As a general practitioner I have attended European ladies in all kinds of ailments, but I have never experienced the kind of difficulty suggested in this paragraph. On the other hand I can recall many instances, not in one but in several stations, where my services were sought for and remunerated, when European I. M. S. and R. A. M. C. officers were available for free medical attendance. I do not deny, however, that individual cases may happen, but to ask for legislation on the strength of isolated cases is neither desirable nor practicable. Because, if the suggestion be taken seriously, it would mean either that Indian I. M. S. men should be excluded from headquarters stations, civil and military, or that two men should be employed, one European and one Indian, each to practise in his own respective community.

The scheme is not satisfied by demanding the maintenance of present proportion of Europeans in the service (para. 16), but it actually demands more European employment in the civil, which can only mean less Indians.

My excuse for going into the details of this question is that a false issue has been raised which in my opinion is likely to prove harmful to the harmonious co-operation of the two communities.

(3) *The scheme demands an increase of Indian Medical Service officers from 1·2 to 3 per mille of army strength.*

The pre-war strength of the Indian Army was roughly 150,000. In peace time a bed accommodation of 5 per cent. sick and 1 medical officer per 50 beds was provided. This gave 7,500 beds and 150 medical officers.

Calculated at 1·2 per mille, we have 180 medical officers, or a margin of 30 over actual requirements. This is undoubtedly too small. From paragraph 4, Scheme B, we learn that 269 Indian Medical Service officers were employed in the military service, which gives an actual margin of 119 medical officers instead of 30. This is better. But it is better still, as the shortage is only apparent and not real, when we remember that the smallness of numbers is the result of extravagant dispersion of the medical staff by the regimental system.

Further, the shortage is made good by the R. A. M. C. officers filling a number of collateral charges and administrative appointments, which is not included in these figures.

On raising our demand to 3 per mille of strength we get 450 medical officers against 180 and 269 and a margin of 300, against 30 and 119.

Allowing 112 officers (25 per cent. of 450) to proceed on leave we still have a margin of 188, i.e., more than the original total strength of 1·2 per mille. This seems ample and intelligible. But when a demand is made for a thousand medical officers we pass from military into civil calculations, and the benefit of the increase is really demanded to go to the civil and not the military department. It is also noteworthy that the number of Indian Medical Service employed in the civil is quoted as 398 in paragraph 4, where increase of strength is demanded, while in paragraph 13, where the residuary requirements are considered, the figure quoted is 506.

(4) *Reserve*.—The bearing of these figures on reserves would be to multiply the defects referred to under the paragraph "reserves." A provision may be said to have been made, namely the periodical reversion of civil I. M. S. men for military duty. This arrangement, besides upsetting the civil department periodically, would mean in practice that whereas at present the civil I. M. S. expects compensation for reversion to military duty once in a way, under the new scheme he will be demanding it every five years.

Scheme C.

The same objections apply to this scheme as to B. Its provision of reserves is defective and it retains the present relationship between the civil and the military side, with its attendant defects.

Scheme D.

The objections to this scheme are :—

(1) *It is halting*.—It recognises the evil of the combination of the civil and military side of the Indian Medical Service, and attempts to minimise it by lending 10 per cent. military I. M. S. men only, to the civil, instead of an unlimited number. It is not a cure; it is palliation. I believe the practice of giving commissions to military officers is obsolete in the civil service.

(2) *Impracticable*.—It suggests that the 10 per cent. military I. M. S. in the civil and all the civil medical service men should revert to military duty every five years for six months' military training.

(a) No medical practitioner would be willing to break up his lucrative practice every five years. It will cause discontent, *vide* paragraph "reserves."

(b) It will cause periodic dislocation in civil administrations.

(c) It is not demanded of civil medical men anywhere else.

(d) Military training is not such an intricate "science" that it requires keeping up-to-date every five years, *vide* paragraph 3, general considerations.

I accept scheme "D" with the following modifications :—

Military side . . . Royal Indian Medical Corps.

Head of Corps and administration . . . Royal Indian Medical Corps.

Strength.—Four per mille of British and three per mille of Indian army strength of fighting men and followers.

NOTE 1.—Sufficient numbers should be retained for peace requirements on military duty.

2.—25 to 30 per cent. on leave.

3.—7 to 12 per cent. or more of officers under 15 years' service to be attached in rotation to civil hospitals in large centres for professional work for 3 to 7 years.

Advantages—

- (a) keeps whole strength on military side.
- (b) gives opportunity for private practice.
- (c) obviates study leave.

Recruitment.

Medical staff.

(1) Medical officers.

- (a) Present Indian Medical Service.
- (b) Temporary Indian Medical Service with British qualifications and report of good work.
- (c) R. A. M. C. under 10 years' service permanent transfer.
- (d) R. A. M. C. seconded for term of Indian tour.
- * (e) Open competition in England of medical men, Europeans and Indians, with British qualifications.

(2) *Sub-assistant surgeon* class to be abolished.

(3) *Nursing sisters* to be of the same standing and qualifications as the Q. A. M. N. S. I. for service with Indian section.

Superior personnel.

Warrant officers, non-commissioned officers and men trained as ward masters, store-keepers, clerks, dispensers, and nursing orderlies.

Mental personnel.

Cooks, bhisties, dhobies, sweepers, tailors, carpenters, barbers.

For British section.

Complete R. A. M. C. section seconded during Indian tour, for service with the British section. Assistant surgeon class to be abolished.

NOTE.—Sufficient number of Indian personnel for peace requirements to be retained on the military side and the balance lent to and distributed in Government civil hospitals for duty. This will form reserve of the Corps. These men will revert to military duty for two months every three years up to the age of 40. They will be examined every year for physical fitness for military duty.

Combined station hospital.

† One commanding officer and two seconds-in-command—one for each section.

The scale of equipment, clothing and dieting on the Indian side to be revised and brought up-to-date.

NOTE.—One surgeon and one physician should be available in each division for consultation.

Specialist appointments as before.

A Staff College.

Staff college to be established in a central place for the training of medical officers and the men of the Corps.

Civil side.—A separate civil medical service.

Name.—Indian Civil Medical Service.

Head.—Director General, Indian Civil Medical Service.

Surgeon-General with Local Governments as before.

Strength.—According to civil requirements.

Recruitment.

1. *Superior grade*.—(a) Open competition in England and India of European and Indian medical men possessing British and Indian qualifications. The successful Indian candidate to go to England for post-graduate training.

* I am aware that a general demand exists in this country for holding simultaneous examinations in India. But from the experience I had of the temporary Indian Medical Service men I must confess that I am not satisfied with the indigenous training and I am afraid that I must vote with those who insist upon British qualifications at least for some time to come. This demand can be met by holding simultaneous examinations in India and requiring the successful candidates to undergo post graduate training in England.

† Thousand bed hospitals might be established in large stations like Lucknow, Rawalpindi, Quetta, Peshawar, Bangalore, Secunderabad, Poona, Mhow, and Meerut. This will create additional number of colonels' appointments.

(b) Temporary Indian Medical Service officers possessing British qualifications and good report of work in war.

NOTE.—Standard of examination, pay and pension, same as R. I. M. C. When serving with military, corresponding ranks according to service.

* (c) Selection in open market of European and Indian medical men for research and professorial appointments. Special scale of pay, prospects, and qualifications.

2. *Provincial services.*—Assistant surgeons with Indian qualifications. They may be promoted to (c).

NOTE.—(a) As a condition of service they will undergo military training for three months after admission and subsequently one month every three years.

(b) They are military reserve in emergency up to 45 years of age.

(c) On military duty will perform professional work and not administrative.

(d) The superior grade should draw same pay and hold same rank as R. I. M. C. of equal service, and the provincial services the same as warrant officers.

3. *Nursing sisters.*—Nursing sisters of civil hospitals might be enlisted on similar terms to form a military reserve.

4. *Sub-assistant surgeon.*—To be abolished.

Civil medical practitioners.

No use is suggested in the schemes to be made of the private practitioners. There is quite a number of them to be found in all large towns. Some of them are well qualified and possess European training.

I suggest that some of them might be usefully employed as honorary surgeons or physicians in civil hospitals. This will economise the I. C. M. S. staff, and bring the private practitioners into touch with the services, so that in time of emergency they may be relied upon as a further reserve.

The Yunani and Vaidic systems.

No scheme of medical reform can be complete without taking some notice of these ancient systems.

It is no use shutting our eyes to the fact that these systems have played in the past and are playing to this day a very important part in the Indian economy. Millions of people flock to them every day for relief or cure. If the hakim did nothing, but harm, if he always killed but never saved, is it inconceivable that so many people, no matter how ignorant they may be, would trust their life and health into his hands? In the fact of this *prima facie* evidence it is unfair to deny some good to the hakim. The attitude of lofty contempt which

the profession has adopted towards these worthies is unwise. In the first place it has made the hakim a martyr in the public eye. The hakim is more popular to-day than he was ten years ago. One often hears from the lips of the well educated Indian gentlemen marvellous stories of cures by hakims, where eminent doctors had failed. In the second place it has given rise to a class of quacks and charlatans of all degrees, as can be evidenced by the advertisements in the Indian press.

I have studied these systems, but I hold no brief for them. All I suggest is that by adopting a more sympathetic policy we can make these ancient systems useful to the poor in remote rural districts, which lie beyond the reach of our dispensaries. At present the hakim has no prescribed course of training and passes no examination and it is difficult to differentiate between a respected and popular hakim and a quack. I suggest that, as a first step, facts should be collected with regard to the number of hakims, their *modus operandi*, the length and the course of training, etc.; and as a second step, to persuade these men to fix a course of training of their own and a system of examination and granting of certificates, etc.

After this has been done, it would not be difficult to introduce, by degrees, modern sciences into their curriculum and by these stages to bring them into line with modern requirements. I know that a number of hakims and vaidas realise their shortcomings and are willing to learn and remove defects, but they want a helping hand.

Advantages of modified scheme "D."

1. Removes defects of organization.
2. Makes the service homogeneous and uniform with the R. A. M. C. and the parts of the two machines interchangeable.
3. Removes sources of friction between the two services.
4. Removes the colour bar by recommending simultaneous examination.
5. Maintains the European standard of qualifications by requiring successful Indian candidates to undergo post-graduate training in Europe.
6. Reserves.
 - (i) Keeps whole strength on military side.
 - (ii) Employs the nursing and menial staff in civil hospitals.
 - (iii) All Indian civil medical service.
 - (iv) Private practitioners.
7. The interests of the civil are not subordinated to the military.

COMMUNICATIONS RECEIVED FROM LOCAL GOVERNMENTS AND VARIOUS BODIES AND INDIVIDUALS WHOSE ORAL EVIDENCE WAS NOT TAKEN BY THE COMMITTEE.

Letter No. 1044-Medl., dated the 29th March, 1919, from the Secretary to the Government of Bengal, Finance Department, to the Secretary, Medical Services Committee.

I am directed to acknowledge the receipt of your letter No. 17, dated the 28th January, 1919, requesting an expression of the opinion of the Local Government on certain specific points connected with the enquiries of the Reorganization Committee. As was verbally explained to the members of the Committee, the shortness of the time allowed, coupled with other pressing calls on the attention of the Governor in Council, precluded him from submitting his views through a representative to appear before the Committee during their recent visit to Calcutta, and it is regretted that this should unavoidably have been the case. The opportunity for personal discussion would otherwise have been welcomed, but since it has passed, resort must be had to letter.

2. Of the six points mentioned in your letter under reference, the most important are the first two, namely, the desirability or otherwise, of creating a unified superior medical service for India, both for military and civil duties, and the best method of giving effect to such a proposal were it adopted.

At present, to use the words of the Public Services Commission, "the civil medical administration of India is dependent in the main on the military requirements of the country," and that this is true of Bengal, as elsewhere, is borne out by the annexed statement showing the distribution of the various provincial medical appointments. It is as well to recall the finding of the Public Services Commission on the working of this organization generally, as contained in the following quotation :—

"From the enquiries which we made, we are satisfied that, under the existing arrangements, the civil medical work of the country has hitherto been economically and satisfactorily performed, and that no case has been made out, either on the ground of expense or of efficiency, for ceasing to employ the medical war reserve of the army in India on civil duty. If, however, it should hereafter be discovered that the medical cadre of the army in India, as determined solely by military requirements, is insufficient to meet the civil medical needs of the administration, we consider that the Gov-

* Notwithstanding its much praised professional excellence, the I. M. S. as a whole is not such a wonderful service as we are led to believe. With the exception of a few names which can be counted on one's fingers it consists of men of average ability. With all the advantages of his official position, of well equipped hospitals, X-Ray institutes and a well trained staff which he freely uses for the benefit of his private practice, the I. M. S. officer is losing ground in open competition with the private practitioner whose education, we are told, is poor and defective.

ernment should obtain such additional assistance as may be necessary by some form of civil recruitment to its civil medical service. * * *

"Meanwhile we are satisfied that the machinery of the present system has stood the test of previous wars. Since, however, our enquiry in India was concluded, it has been exposed to the more serious strain of the present war, to meet the needs of which 286 officers of the Indian Medical Service and 113 of the Indian Subordinate Medical Department, had been recalled from civil to military duty down to the 8th April 1915. This has obviously produced a new situation, calling for fresh investigation, and we recommend that this be undertaken at the conclusion of the war and in the light of experience gained during its duration. For the purposes of this annexure we shall assume that the existing system will be maintained in its essentials. * * *

"We lay stress on the necessity for calculating separately on their merits the needs of the army and of the civil administration, and for abandoning the idea that the civil medical administration should be dependent on the requirements of a military reserve. At the conclusion of the present war it should be possible to estimate more closely than has hitherto been the case what are the military requirements, and to what extent these can be met from private practitioners in England or in India. Calculations should also be made and reviewed from time to time of the civil needs of the country, and a purely civil machinery should be created to meet all civil requirements. The officers forming the medical reserve of the army should be admitted to the civil cadres so formed. But if, after an estimate has been made of the military requirements in time of war, it is found that the number of Indian Medical Service officers available for civil employment, as determined solely by military requirements, is insufficient for the needs of the civil administration, then every civil medical post for which no war reserve officer is available should be filled by civil recruitment. * * *

"We recommend further that, if the experience of the present war leads to such an increase in the military reserve as would seriously endanger the maintenance of a civil element in the civil medical administration, it should be considered whether a minimum number of civil officers in civil medical service should not be fixed. We also think it important that military officers, who are admitted to the civil cadres, should take their places with the civilian officers in the department in the same way that officers of the army hold Indian Civil Service posts in the non-regulation provinces, or are employed in the public works or railway departments. It should no longer be the case that the civil departments should be the adjuncts of the military services. We also think that steps should be taken to secure that, even under the gravest war conditions, the civil cadres shall not be unduly depleted, and in particular that no dislocation of the educational and scientific work of the country shall take place."

"Briefly, the Commission hold that in the past the existing system had answered well, though it required re-examination in the light of the experiences of the war. However, they contemplated its probable continuance, subject only to some minor adjustments designed to prevent the sacrifice of civil needs to military exigencies.

3. From the point of view of organization the more important recommendations of the Commission may be summarized as follows:—

- (a) Some form of State medical service is needed (paragraph 3).*
- (b) Regular civil medical services should be constituted—the Indian civil medical service to be entrusted with the higher duties and for the whole of India; and provincial civil medical services, separate for each province, to carry out the duties of minor importance (paragraph 6).
- (c) Officers of the Indian Medical Service admitted permanently to the Indian civil medical service should be at the disposal of the military authorities only if they are not of administrative rank and only in the event of war (paragraph 6).
- (d) The preliminary period in military employ of officers of the Indian Medical Service

lent to the civil side should not exceed five years (paragraph 10).

- (e) No system of direct recruitment is possible for the balance of superior appointments not already bespoken to meet military requirements. The present practice of promoting assistant surgeons (civil and military) might be maintained (paragraph 11).
- (f) Military officers holding professorships, chemical examinerships and whole-time asylum charges should be excluded altogether from liability to recall to military duty (paragraph 32), but scientific chairs, chemical examinerships and alienist appointments might be thrown open to the public as well as to the officers of the civil medical service (paragraph 33).
- (g) The Bacteriological Department should not form part of any military organization, but be treated on the lines proposed for scientific professorships (paragraph 40).
- (h) The Sanitary Department (as now) should continue to be recruited both from the Indian Medical Service and outside (paragraph 43).
- (i) Recommendations relative to the Jail Department were withheld (paragraph 48)."

4. These conclusions have been recapitulated in order to emphasize the opinion of the last responsible body which, prior to the present enquiry, investigated the working of the service on the side with which the Governor in Council is primarily concerned, namely, its civil aspect. The Local Government are mainly interested in the efficient discharge of the civil medical duties of the province, and they accept the verdict that, subject, it may be, to minor modifications of detail, the present system, from that point of view works fairly satisfactorily. The advantages from the military standpoint of offering to its medical recruits the attractions of civil employ, and in times of peace maintaining a considerable reserve at the cost of the civil administrations, are obvious, and the provincial Government would scarcely be justified in objecting to the system unless it could be shown that their interests were being wantonly sacrificed. So far, that has not been the case; the strain of the recent war was excessive and greater than anything which, it is to be hoped, may recur, and although the civil cadre was regrettably depleted, and the standard of work inevitably deteriorated in consequence, yet no actual break down occurred, and the incidental inconveniences, serious though they were, must be accepted as part of many others arising from this great emergency. In essence, the subsidiary recommendations of the Public Services Commission appear to be sound, and they may advantageously receive the endorsement of your Committee.

5. Otherwise the organization of the medical service in India has to be judged mainly by military considerations, and with these the Governor in Council is necessarily less conversant. From schemes which have been brought to his notice by your Committee it would appear that various solutions have been mooted, the main features of which are apparently as follows:—

I. That the Royal Army Medical Corps should absorb the existing Indian Medical Service supplying officers to the civil side to the extent, say, of 10 per cent. of the latter service, on five-yearly terms, interspersed with at least one year in military employment. Otherwise the needs of the Indian army and of the civil administration to be met by an auxiliary corps of Indians and Anglo-Indians, to be given some preliminary subsequent periodical training in military subjects, and with a liability for service outside India the same as for the Indian army.

The Governor in Council is doubtful whether this plan would attract to India, Europeans of the present calibre of the Indian Medical Service to whom the attractions of civil employment, on the present scale, are understood to appeal as the deciding factor, while the ordinary civil administrations would not be furnished with officers of the existing standard, which should not be allowed to deteriorate, looking especially to the needs of the European personnel in Government services. At the same time the exclusion of Indians from the superior service would be difficult to justify, while the European officers

* The references are to annexure XII of the Commission's Report.

of it might be lacking in adequate acquaintance with Indian conditions.

II. That in place of the existing dual system of Royal Army Medical Corps and Indian Medical Service, there should be one unified service for India, to which a considerable number of Royal Army Medical Corps officers should be seconded for five-year periods of duty. Otherwise, apart from the admission of some military assistant surgeons with registrable European qualifications, entry to the new service to be by competitive examination in the United Kingdom on similar lines to those at present followed. A feature of the scheme would be an increase in the present number of medical officers with the Indian army, thus necessitating a corresponding increase in the number of officers in reserve in civil employ.

The proposal seems to be governed largely by considerations affecting the Royal Army Medical Corps, with which the Governor in Council is not well acquainted. If, as would appear probable, the disappearance of the Royal Army Medical Corps from India was opposed on military grounds, the solution suggested presumably fails.

III. A third scheme appears to preserve the existing separate civil and military organization, while incorporating in the Indian Medical Service (to be called the Indian Medical Corps) a certain number of Royal Army Medical Corps officers (either permanently transferred or seconded), limiting the tours of civil duty to five years, and adding a special reserve from private practitioners.

The staffing of the civil side by officers liable to reversion to military at five-yearly intervals cannot but be prejudicial to the administration, and the idea is open to objection on that ground.

6. As has been said, military considerations are so largely involved in all these suggestions that the Governor in Council finds it difficult to advise. All he can say generally is that, so far as he is primarily concerned, he has no particular wish to see any marked departure from the existing organization, subject only to such modifications of detail as may be deemed to be expedient.

7. I am now to answer briefly the specific points put in your letter No. 10—14, dated the 23rd February, and the number references below are to the questions* as there set forth :—

(i) (a) *Compulsory military training of some portion of the civil assistant and civil sub-assistant surgeon cadres.*—At present sub-assistant surgeons, but not civil assistant surgeons, are liable for military duty, and some military training of the former (at the cost, presumably, of the military estimates) should not, therefore, present insuperable difficulty, even as regards present incumbents. Assistant surgeons showed no great keenness to volunteer for war service, and the obligation is not likely to be popular. All but the most junior men are hampered by family ties which they find it difficult to break. On the other hand, competition in Indian medical circles for Government appointments is keen, and it is doubtful if the departure would upset recruitment. The best course would seem to be to constitute a military reserve and to give additional remuneration (from the military estimates) to those who were willing to enter and qualify for it. The Local Government would not object to the trial of such an experiment, but it is to be remembered that in Bengal there are signs that local bodies which at present employ Government officers of this class may seek to replace them by private practitioners recruited by themselves. In that event the size of these cadres would be materially diminished.

It is understood that Lieutenant-Colonel Calvert, Principal of the Medical College, Calcutta, strongly represented to your Committee the overcrowding of the private Indian medical profession due to the rush of entrants to the institution which has been so marked recently. In one sense, his remarks are undoubtedly correct, in so far as these medical graduates at present show a marked disinclination to go into the districts, and remain in the large towns where the supply is in excess of the demand. On the other hand, viewing the medical requirements of the province as a whole, it cannot be said that to the ordinary villager existing facilities for western medical treatment are adequate or even appreciable. The whole problem turns on the

willingness of graduates to establish themselves in the mufassil and extend the demand for western medicine by demonstrating its superiority to indigenous methods. In view of their unwillingness Lieutenant-Colonel Calvert pressed for a larger number of men with lower qualifications, and that demand the Local Government are endeavouring to meet by increasing the capacity of the two existing medical schools and the opening of a third at Burdwan.

(i) (b) *Whether all existing superior appointments should be reserved for Indian Medical Service officers, outsiders being admitted to new special posts only.*—It is difficult to give a general reply. The Local Government has no intention of making any radical departure from present practice, but in so far as military and civil assistant surgeons occupy superior posts now, their claims cannot be brushed aside, while in some of the smaller civil surgeoncies it can scarcely be said that an Indian Medical Service officer is required. In the past, Indian Medical Service officers have been refused by the Government of India in instances in which the Local Government would have been willing to employ them.

(ii) *Whether additional superior appointments should be filled by Indian Medical Service officers or from outside.*—*Primâ facie* the Indian Medical Service affords the best field open to the Local Government from which to fill medical appointments, but there are other factors and each case must rather be judged on its merits. It is undeniable that the superior medical cadres in the province could advantageously be strengthened; the process depends largely on the funds available. In fresh medical appointments under local bodies, e.g., health officerships, etc., the non-official demand in Bengal would be for the employment of private practitioners. There are other new posts which would be useful, e.g., teaching or those connected with the larger hospitals, in which Indian Medical Service officers might be required, but the Local Government are not prepared to give any general undertaking as to how any fresh posts created hereafter might best be filled.

(iii) (a) *Should the appointment of an outsider (European or Indian) to a superior appointment be made conditional on his joining the army reserve.*—There would seem to be no reasonable hardship, and appreciable advantage, in enforcing this condition; it would not probably deter would-be candidates. It is to be understood that any military training required would not interfere unduly with the civil duties which such an officer would be required to perform.

(iii) (b) *Whether military medical officers or civilian doctors are to be preferred in superior appointments.*—The experience with civilian doctors in these capacities is limited. There has been one definite failure, but it is impossible to generalize. The Indian Medical Service officer should ordinarily be better qualified and to be preferred in that aspect, but his military training scarcely affects the question, which turns rather on his professional training and experience.

(iv) *Whether a military reserve be formed on reasonable terms from among independent medical practitioners.*—The European private practitioners are too few to be worth considering; it is understood that some voluntarily offered their services during the war. Judging by the facts of the last four years, the Bengali private practitioner will not ordinarily volunteer, so little help is to be looked for from this source.

(v) *Sufficiency or otherwise of the present leave reserve in civil employ.*—In this Government letter to the Government of India, No. 535-T.—Medl., dated the 15th June 1910, the opinion was expressed that, apart from study leave, the reserve of 20 per cent. with four supernumerary officers was adequate for provincial needs, but the recommendation was made that, if study leave was to be granted freely, the reserve should be increased to 25 per cent. The Surgeon-General, however, considers that even in respect of the grant of long leave to those seeking it the reserve is insufficient, as demonstrated by past experience. It would seem safe, therefore, to raise it to 25 per cent.

(vi) *Possibility of giving free treatment to the families of civil officers in the mufassil.*—The concession would, of course, be appreciated by the other Government services, though, if granted at all, it is not clear why it should be confined to the mufassil. It would obviously add to the duties of Government medical offi-

* See Questions for representatives of Local Governments, Volume III.

cers and diminish their emoluments; it is not likely, therefore, to find favour with them.

(vii) *Desirability of giving free hospital treatment in selected centres to the families of Government officers.*

—Here, equally, the services would doubtless welcome the concession, but outside Calcutta, Darjeeling, Dacca and Chittagong, hospital facilities of a good type are few. Ordinarily, too, in the mufassil, the *sadar* hospitals are not Government institutions.

Both this and the preceding question seem to affect service conditions generally rather than the reorganization of the Medical Department.

(viii) *Expediency of employing a few travelling consultants and medico-legal experts.* The idea does not commend itself to the Local Government and, at any rate in Bengal, it is doubtful if it would be workable.

(ix) *Acceptability of a scheme under which Indian Medical Service officers other than those in residual or indispensable appointments should revert to military duty for one year every five so as to maintain their military efficiency.*—Allowing also for ordinary leave and study leave, the suggestion would entail constant interruptions in the service of officers on the civil side to an extent which would be seriously prejudicial to efficiency. The idea, therefore, is open to objection. Neither is it likely to be popular with Indian Medical Service officers themselves. On the other hand, the Local Government recognize that improved arrangements for the maintenance of touch with military matters among the war reserve are necessary, and would be prepared to accept a modified scheme which did not involve so great a dislocation of civil work.

(x) *Possibility of reconciling Indian aspirations for increased employment in the medical service with the preference of European officers for treatment by European doctors.* The problem is insoluble, but it will become increasingly less acute with the further Indianization of the services foreshadowed under the Reforms Scheme. That is to say, the official personnel in some stations will tend to become mainly Indian, and if Indian medical officers were posted to such charges, the difficulty would not arise.

(xi) *Whether with the recall of Indian Medical Service officers to military duty the quantity and quality of civil medical work have deteriorated.* The Surgeon-General and Inspector-General of Prisons, who are in the best position to judge, both answer this question in the affirmative, and it is more or less inevitable that this consequence should have ensued. The same is true of other branches of the administration. With a short emergency things tend to right themselves fairly quickly on a return to normal conditions. The length of the recent war has, of course, been more detrimental, but the result has to be accepted unless the whole system of medical recruitment is to be changed.

8. The foregoing remarks cover more or less points (iii) to (v) in your letter of the 28th January, 1919, and as regards point (vi), the future organization of the medical stores department, it may only be noted that it is doubtful whether any system of indenting upon the Government stores would commend itself to non-Government institutions; in this province only three such are at present so supplied. They would ordinarily regard private firms as more expeditious and cheaper, and would resent interference with their independence.

Enclosures.

1.—Statement showing the superior civil medical appointments in Bengal.

(a) Medical Department proper.

Appointments.	No. of officers.	REMARKS.
1. Surgeon-General	1	Reserved for Indian Medical Service.
2. Principal and Professors of Medical College.	10	8 reserved for Indian Medical Service. 2 open to private practitioners.
3. Chemical Examiner to Government and Professor of Chemistry.	1	Reserved for Indian Medical Service.
4. Director and Professors of the School of Tropical Medicine.	4	Ditto ditto.
5. Personal Assistant to Surgeon-General	1	Ditto ditto.

Appointments.	No. of officers.	REMARKS.
6. Police Surgeon, Calcutta	1	Reserved for India Medical Service.
7. Superintendent, Campbell Medical School and Hospital.	1	Ditto ditto.
8. Surgeon to His Excellency the Governor.	1	Not exclusively reserved for Indian Medical Service.
9. Superintendent, Central Lunatic Asylum, Berhampore.	1	Held by Indian Medical Service, but not exclusively reserved for that service.
10. Resident Medical Officers, Medical College Hospital.	3	Reserved for Indian Medical Service.
11. Surgeon-Superintendent, Presidency General Hospital	1	Ditto ditto.
12. Resident Surgeons, Presidency General Hospital.	2	Ditto ditto.
13. Civil Surgeons	28	16 reserved for Indian Medical Service. 12 reserved for other services (including 5 for civil assistant surgeons and 4 for military assistant surgeons).
14. Protector of Emigrants	1	These appointments are now vacant; the existing arrangements are temporary, and the question of reserving these posts for the Indian Medical Service will be considered when they have to be permanently filled.
15. Port Health Officer, Calcutta.	1	

(b) Jail Department.

1. Inspector-General of Prisons.	1	Reserved for Indian Medical Service.
2. Superintendents of Central Jails.	4	Ditto ditto.

(c) Sanitary Department.

1. Sanitary Commissioner	1	Not exclusively reserved for Indian Medical Service.
2. Deputy Sanitary Commissioners.	3	Open to both Indian Medical Service and private practitioners.
3 Ditto ditto.	2	Open to private practitioners.

(d) Botanic Gardens.

1. Superintendent, Royal Botanic Garden.	1	It has been held for several years by an Indian Medical Service officer, but it is not exclusively reserved for that service. It is in the gift of the Secretary of State.
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II.—Minor medical appointments which are reserved for military assistant surgeons.

1. Assistant to the Superintendent, Medical College Hospitals, Calcutta	1
2. Apothecaries to Medical College Hospitals, Calcutta	2
3. Assistant to the Surgeon-Superintendent, Presidency General Hospital	1
4. Apothecaries to Presidency General Hospital	5
5. Deputy Superintendent, Campbell Hospital, Sealdah	1
6. Superintendent, Albert Victor Asylum for Lepers, Gobra (Calcutta)	1
7. Assistant Port Health Officer, Calcutta	1
8. Assistant to the Civil Surgeon, 24-Parganas	1
9. Superintendent and Medical Officer, Juvenile Jail, Alipore	1
10. House Surgeon, Howrah General Hospital	1
11. Deputy Superintendent, Central Lunatic Asylum, Berhampore	1
12. Medical Officer attached to His Excellency the Governor's staff dispensary	1
13. House Surgeon, Mitford Hospital, Dacca	1
14. Assistant Superintendent of Emigration, Goalundo	1

15. Medical Officer, Police Training-School, Sarda	1
16. Resident Surgeon, Eden Sanitarium, Darjeeling	1

17. Medical Officers, Eastern Bengal Rail- way	6
18. Certifying Surgeon of Factories	1
N.B.—All other minor appointments are held by civil assistant surgeons and sub-assistant surgeons.	

Letter No. 80-M.—5.X.-3, dated the 20th May, 1919, from the officiating Secretary to the Government of Burma, to the Secretary, Medical Services Committee.

I am directed to forward for the information of the Medical Services Reorganization Committee a memorandum giving the views of this Government on the questions referred to the Committee (Enclosure No. 1). This memorandum is sent in lieu of the deputation of an officer to convey these views to the Committee. It must, however, be clearly understood by the Committee that the issues placed before the Local Government are so complex and important, that, in the limited time allowed, it is quite impossible for any Local Government to bind itself definitely to any details.

I am also to forward for the information of the Committee a note prepared by three Indian Medical Service officers, Lieutenant-Colonels Entrican, Barry and Dee (Enclosure No. 2). The note expresses the views of three officers of experience who are concerned to see the Indian Medical Service retained as a service on present lines but with the necessary reforms.

Enclosure No. 1.

Memorandum giving the views of the Government of Burma on the questions referred to the Medical Services Reorganization Committee.

The subject of the reconstitution of the Indian Medical Service has been placed before the Local Government in the shape of four alternative schemes, marked A, B, C and D, and a series of questions, some to be answered by the Local Government and some by members of the services concerned. There are, however, some preliminary principles which must be determined upon, after full examination of the various issues involved, before any satisfactory scheme can possibly be evolved. The whole question has arisen in its present acute stage for two main reasons:—

First, on the general ground that the pay and prospects and privileges of the Indian Medical Service have ceased to be attractive among the best men turned out from the medical schools in England; that the quality of new recruits has seriously deteriorated; that the necessary European element has been greatly diminished; and that the prestige of the Service has suffered so severely, both in the eyes of the public and of the profession, that the maintenance of its hitherto high standards, both of professional work and of duty, is imperilled.

Secondly, on the purely military ground that the present method of using the Indian Medical Service as a war reserve has broken down because officers so long in civil employment have not been found to have the experience and training required for medical work with the armies in the field in the greatest war in the history of the world. There appears to be no similar record of breakdowns in the case of all the minor campaigns in which Indian Medical Service officers have been employed in the years prior to the war. Are we then to prepare an army for Armageddon, or only for minor campaigns?

2. The standpoint of the four schemes placed before the Local Government is military, the object being to increase both the strength and the efficiency in the field of a military medical service for India. The interests of the civilian population and of the Local Governments responsible for civil medical administration are entirely subordinated in these schemes to this object. Though the schemes vary greatly in details, yet they all have this feature in common; they are designed mainly for military needs, civil needs having to fall in with the scheme as best they may and whether they like it or not.

3. These two objects are mutually incompatible. You cannot have a thoroughly efficient civil medical service if it looks upon its own particular duties to be militarily efficient, and its duties to the civil administration under whom it is placed to be merely subsidiary, and interludes in the career of a military doctor. The first question to be asked is, why is it necessary to accentuate the military element in the Indian Medical Service and subordinate the civil aspects of the case to the great and only desideratum of military efficiency? While the German menace and the competition in armaments were hanging over the world, stringent measures of this kind were not taken; now that the German menace has been happily removed, and (unless the proceedings at Paris are an entire farce), the danger of great world wars has become remote, the further militarisation of the Indian Medical Service is put forward as the main objective for consideration. With this objective the Local Government is entirely out of sympathy. It, of course, recognises that in the event of any serious war the civil medical officers who may be in India at the time must constitute a reserve to reinforce the regular medical staff of the army. But the army must be content to have the benefit of the professional skill of these civil medical officers and not demand from them efficiency in the routine and the details, and complete acquaintance with the administrative medical duties of an army in the field which can be demanded, and can be obtained, only from medical officers who have made the army their career. It is no good aiming at two mutually incompatible objects, and the time appears to be singularly unsuitable for placing the civil administration of any country in the hands of military administrators whether they belong to the combatant or to the auxiliary forces of the army. If the civil medical administration of the country is only to be entrusted to military doctors fully equipped and trained for medical administration in the field, then the civil administration is bound to suffer and to be subordinated to military interests.

4. The alternative policies, therefore, are either—

- (a) to accept this position and to sacrifice civil interests to military; or
- (b) to make an efficient civil medical service and be content with the reserve thus available to assist in the professional medical work required at a time of war.

5. The second policy is the one that commends itself to the Government of Burma. And indeed, whatever breakdown may have occurred during the war because of the inexperience of Indian Medical Service officers in the administrative duties required of medical officers in the field, the charge has never been brought against that service that it failed in its purely professional work. On the contrary, although the Local Government is necessarily not in a position to speak with authority, there is yet a large volume of opinion that a great deal of such breakdown as occurred was due to the wasteful use of the officers that were available. Large numbers of medical officers were kept in places where they had nothing to do; officers with special surgical skill were set to do work which called rather for administrative talents and experience than for specialised surgical or medical work.

The Local Government desires to call the attention of the Committee to the Burma Government's letter* No. 475—5X-4 of the 13th February 1918, to the address of the Government of India in the Home Department, and particularly to paragraphs 3 to 6 of that letter. It was there suggested that the source of supply

of the Indian Medical Service, in future to be converted into a civil medical service, was to be the Royal Army Medical Corps so far as the European element was concerned, and that the Indian portion of the Indian Medical Service should be otherwise appointed. The Local Government would now like to elaborate this proposal and to endeavour to meet at the same time some of the criticisms which have been, or might be, advanced against it.

6. One of these criticisms is that Indians will not be satisfied by a system which excludes them definitely from taking part in supplying the medical staff for the Indian army. This criticism is a valid one, and must be met. The best method of meeting it would be to provide that for a certain definite number of vacancies, Indians who have obtained certain medical qualifications in England shall compete in India for the Indian branch of the Royal Army Medical Corps. It is suggested that, even in this case, Indian aspirations will not be fully met and that the Indian branch of the Royal Army Medical Corps will be looked upon as inferior. But the answer to this criticism is, *first*, that the Royal Army Medical Corps is an all-Empire service and not an Indian service, and that no promise or announcement has hitherto gone further than to guarantee a place for Indians in the purely Indian services. If they were allowed to enter the Royal Army Medical Corps in England by the open door of competition, there would be no guarantee that their numbers would be restricted to the numbers required, and they would be entering a service which involved their employment, not merely in India, or even in Asia, but in such places as the United Kingdom itself, Egypt, Africa, and so forth. Furthermore, if Indians desired to be employed solely in India or in countries administered from India, either as part of the Empire or under mandate of the nations, it is reasonable that the examination for entry into such a branch of the service should be held in India itself and not in England. By this means, and by this means only, would Government be able to regulate the number of vacancies to the number of Indians it required. No such regulation would be possible at a single examination held in England, at which European and Indian candidates competed together. The number of vacancies for Indians offered for competition in India would depend upon the proportion decided between the European and Indian personnel in the Indian section of the Royal Army Medical Corps and in the Indian Medical Service.

7. Another objection taken to this Government's proposal, as contained in their letter of 1918, is that the chances of employment in India would appear to be so comparatively small to entrants of the Royal Army Medical Corps as to have little or no effect on maintaining the attractions of that service and thereby securing the best men from the medical schools. This difficulty might be got over in the following way. The successful competitors in the Royal Army Medical Corps examination might be given the preference of having their first tour of service in India, such preference being determined by their place in the examination. The result of this would be that entrants into the Royal Army Medical Corps would, if they were high enough in that examination, be assured of early service in India which would carry with it the reasonable probability of their being transferred to the Indian Medical Service.

8. With these modifications, the scheme put forward by this Government in 1918 would seem to meet the necessities of the case. Both the European and Indian elements of the Indian Medical Service (save in the case of the few appointments in that Service that might be reserved for promoted civil assistant surgeons) would be filled by the army, the Europeans from the Royal Army Medical Corps as a whole, the Indians from the Indian section of the Royal Army Medical Corps. Statutory natives of India would be eligible for this branch of the service, which would, therefore, cover the case of Anglo-Indians and domiciled Europeans. But it would be necessary to insist upon medical qualifications of a similar character to those required for the Royal Army Medical Corps examination in England. This principle of a separate examination in India has been accepted by the Royal Commission on

Public Services in the case of the Indian Civil Service. It is true that in the case of that Service the door is still open to the Indian to enter by open competition in England; but that service is the Indian Civil Service and does not include service in other parts of the Empire as the Royal Army Medical Corps does. Consequently there is every ground for discriminating between these Services and making competition in India the sole road of entry into the Indian section of the Royal Army Medical Corps.

9. It is also urged that the completion of a five years' tour of service in India, before transfer to the Indian Medical Service if possible, would be too long a period. In that case this period might be shortened. But this Government does not consider five years as too long. It gives a man an ample chance of training on the military side of the profession, of getting to know the language of the people and of familiarising himself with the country and the kind of life which a career in it involves. It is quite likely that some, who on entry to the Royal Army Medical Corps had expressed a preference for service in India, would change their minds. There have been many Royal Army Medical Corps officers who do not take to the country and are anxious to get transferred to service elsewhere. But, as a general principle, it may be taken as certain that the possibility of obtaining a transfer to the Indian Medical Service would result in benefit both to the Royal Army Medical Corps itself and eventually to the Indian Medical Service in the qualifications and abilities of the candidates who presented themselves.

10. It is not an easy task for a Local Government which is familiar with civil medical administration but is not in any direct contact with military medical administration to pronounce with confidence upon the manner in which civil medical officers should be periodically trained so that they might be of the best use in the event of a war requiring the utilisation of their services with an army in the field. But the Local Government is advised that the mere deputation of civil medical officers to the charge of station hospitals in military cantonments is of no advantage whatsoever for this purpose. An officer who, in his civil work, is in charge of civil hospitals, is not likely to gain in any way professionally by being placed for a short time in military hospitals. He may acquire some temporary knowledge of the routine and red tape inseparable from these charges; but for the purpose of assisting an army in the field he is rendered no fitter by a training which is of this character. If there were (as is apparently contemplated in some of the papers circulated by the Committee) a college or training institution in which a short period of intensive training could be given to medical officers in the duties which are actually required of them when an army takes the field, then there would be a great deal to be said for allowing civil medical officers to be deputed to training of this kind, inconvenient though it might be. But if civil officers are to be taken away from their civil duties no matter at what inconvenience to the civil administration, merely to go through some form of useless training, somewhat similar to the training hitherto given in station hospitals or to the so-called staff training of civil officers during the last year or two, the Local Government has no hesitation in advising against such a system. The suggestion that it would make would be that all officers who, after serving in the Royal Army Medical Corps for a five years' tour of service, or such lesser period as may seem suitable, have been transferred into the Indian Medical Service, where they become civil doctors and drop their military titles, should be counted as belonging to the Royal Army Medical Corps reserve and should, on that account, be liable for short intensive training at an institution specially designed for that purpose. This would apply to Europeans and Indians alike, but should not cover a period of more than ten years' service in the Indian Medical Service. After that ten years, they should in future be reckoned as volunteers for military duty if occasion arose. In that case, they would not be eligible for high administrative posts in the army but would put their professional skill at the disposal of the Royal Army Medical Corps as thousands of civilian doctors have done in England

during the late war. Any attempt to find from the ranks of a civil Indian Medical Service ready-made officers fit to take up high administrative posts with an army in the field is a counsel of perfection and is doomed to disappointment.

11. Under the scheme proposed by this Government, it would be necessary to lay down definitely the number of Europeans and Indians (including statutory natives of India) who were to be employed in the Indian Medical Service and also the proportion, for the requirements of the Indian army, of officers of the Royal Army Medical Corps proper and officers of the Indian branch of the Royal Army Medical Corps. On the first question, it would be necessary for a thorough examination to be conducted by each Local Government of the civil surgeoncies and other appointments in each Province and the determination of the number of these latter which could be assigned to Indians, having regard to the necessity that the European services shall have an adequate supply of doctors of their own race. This matter is one on which the Local Government is not prepared with figures offhand; but, having regard to the hitherto constitution of the Indian Medical Service and the distribution of appointments, it is inclined to think that the constitution of a future Indian Medical Service, under the scheme here adumbrated, should be two-thirds European and one-third Indian, including statutory natives of India. In the one-third Indian should be included medical officers recruited into the Indian Medical Service by a road other than entry into the Indian section of the Royal Army Medical Corps. These roads would include military assistant surgeons, whose training and examination should be such as to entitle them to registrable medical degrees, and civil assistant surgeons promoted from the provincial medical service.

12. The question of the pay of the Indian Medical Service must be considered along with the pay given to other services which have to undergo similar periods of professional training, and with due reference to the fact that all officers entering the Indian Medical Service would have served at least five years in the Royal Army Medical Corps before they entered upon their appointments as civil doctors in the service of the Government of India. The question at once arises as to how far the fact that officers of the Indian Medical Service are allowed to carry on private practice, affects the question of salaries? No doubt when the salaries of Indian Medical Service officers were originally fixed, they had practically no competitors in the field of allopathic medicine and well-to-do Indian families took rather a pride in saying that the civil surgeon was their family doctor. On the other hand, in numerous small districts to which Indian Medical Service officers were posted, the Indian residents of the headquarters town had too little belief in western medicine and were too little accustomed to pay fees to anybody except baid and hakeems to think of employing the English civil surgeon on, it might be to them, very high fees. Any growth in the sphere of private practice which has arisen from education and the larger resort to western medicine by the well-to-do among Indians has been more than counterbalanced by the springing up of Indian private practitioners professing adherence to the allopathic system. Consequently, the cases in which Indian Medical Service officers can hope to draw any substantial income from private practice are limited very largely to the few stray rich men in the smaller places and to consulting practice in the larger cities and towns. In the opinion of the Local Government, the proper course is to ignore private practice altogether in fixing the remuneration of the Indian Medical Service. If it is possible for officers of that Service to claim with justice that their remuneration has been calculated on the hypothesis that they will add to their incomes considerably by private practice, the grievance of the transfer from a place where such a practice is lucrative to a place where it is non-existent or trifling, however much Civil Service Regulations or other Government orders may exclude such considerations, will always be felt, and rightly felt, by the officers aggrieved. The salaries must, therefore, be fixed on the basis of other services, on the assumption that if in any particular place or locality, or on account of special skill, an officer of the Indian Medical Service is able to add

largely to his income from private practice, such income is the just reward of his own skill and exertions. At the same time, the general rule that private practice must not interfere with the carrying out of the official duties of an officer should be more strictly enforced,—a principle which can only be justified if the officer's pay has been fixed irrespective of such income.

13. One of the questions referred to is whether it would not be expedient to grant free medical attendance to the wives and families of all Government officers. Civil surgeons are opposed to this concession. While they do not wish to demand extravagant fees on account of attendance upon the wives and children of officers of other Government services, who in many cases may be on small pay and hard up, they consider that compulsory free attendance upon these wives and families would lead to great abuse of the privilege and to most unnecessary calls by day and by night upon the services of the medical man. There is much justice in this contention. But it seems advisable that while Indian Medical Service officers should be free to retain such fees as they can draw in the open market from non-officials, in respect to their attendance on the wives and families of Government officers, they should be limited to a reasonable scale fixed by the Government with the general concurrence of leading members of the profession. The scale might vary with the salary of the officer whose wife or family requires medical attendance, say a division between officers receiving Rs. 1,500 and over, and officers receiving pay lower than this. Such a rule would impose an automatic check upon too free a resort to the services of the doctor for small ailments, while it would relieve the civil surgeons themselves from the difficult alternatives now placed before them of either asking for a fee which they know will seriously embarrass the unfortunate officer who has to pay it, or else of remitting their fees entirely or charging such small ones as put the Government officer in question under an obligation which may make him uncomfortable, and also create inconvenient precedents which cause other officers in the Indian Medical Service to incur a reputation for lack of generosity because they ask larger fees than some of their brother-officers have demanded in similar cases. The Local Government would, therefore, place attendance on the wives and families of Government servants on the basis of semi-public duty for which a sanctioned scale of extra remuneration is given by the public servant concerned. But it should be made clear that an officer who neglects these official patients for more lucrative non-official ones would be held to have neglected his public duties in pursuit of his private practice.

14. Other matters to which reference has been made in the papers circulated by the Indian Medical Services Committee relate to assistant surgeons and sub-assistant surgeons. On this subject, the Local Government has not had time sufficient to formulate definite views. It is inclined to think that the best method of securing some measure of military training for assistant surgeons and sub-assistant surgeons would be to permit them to enrol themselves in the reserve of the Royal Army Medical Corps. An officer so enrolled, would be liable to be called up for military service in emergency and would have to go through periodic courses of training at the college suggested for that purpose. In that event, he should be entitled to a liberal bonus for thus qualifying himself. It might be desirable that such officers who enrolled in the Royal Army Medical Corps, Indian reserve, should be given an annual bonus by the Imperial Government, in addition to the pay received from the Provincial Government, as a sort of retaining fee in recognition of the obligations which they have voluntarily incurred, all such bonuses and fees being, of course, dependent on their undergoing these periods of intensive training and passing satisfactory tests in the same.

15. In respect to private practitioners, it would be for the Army Department of the Government of India to consider whether the offering of similar bonuses or retaining fees to such practitioners would be worth the expense involved. It is not possible for a Local Government to form an opinion on this question. In all these cases, the bonuses, and the retaining fee, if any, would be dependent on the officer in question being periodically passed fit for service if required. Officers

passed permanently unfit by a Board would necessarily be struck off the roll of the Royal Army Medical Corps reserve and cease to be eligible for any benefits, or liable to any of the obligations involved by enrolment in that reserve.

16. The above suggestions constitute the rough scheme which is at present favoured by the Lieutenant-Governor. If the main principles of the scheme were to be adopted, there would no doubt be a great deal of detailed work required before they could be put in a finished state. This detailed work so far as the military side is concerned is both beyond the province and the capacity of the Local Government to supply. But the main principles for which it contends are, that a completely efficient military medical service and a completely efficient civil medical service are incompatible objectives, and that, so far as civil Governments are concerned, their main duty is to provide the country of 300 millions odd with an efficient medical service and not to sacrifice the interests of the civil medical administration of the country in order to secure the maximum efficiency of an army of say 300,000 in contingencies that may never arise, and which, if they did arise, must be met by exceptional effort. All that it is incumbent upon the civil medical administration to do is to agree to facilities for the periodic training in field duties of the younger men of the service and to place at the disposal of the army, to such extent as can reasonably be spared from civil duties, the medical and surgical skill which the medical practitioners in its service have at their command.

The last principle upon which the Local Government would again lay great stress is that in the case of the medical profession and the medical services the Indian claim for an increasing share in the administration must be limited by the necessity of supplying the European services of Government with a reasonable number of doctors of their own race. There are individual Indians among the officers of the Indian Medical Service of whose medical skill Europeans have been glad to avail themselves; but we cannot legislate by exceptions. The preference for doctors of their own race is a general rule which must govern the decision. Let the Indian officers of the Indian Medical Service enjoy their fair share of professorships, a number of joint civil surgeoncies in the larger places and as much consulting practice as their attainments can win for them; let the Indian private practitioners acquire hospital practice as house surgeons and house physicians in Indian hospitals; but do not seek to thrust Indian doctors upon European officials, their wives and families. It is as unreasonable as it is unwise, and if the great European services require protection when they come out for a life's work in this country, there is no particular in which this protection is more essential.

17. The only other point to which some reference may be made relates to the depletion of medical officers which has been necessitated by the war. There is a sort of general impression in certain quarters, and especially in the Indian press, that the country has carried on well with the make-shift arrangements and that it has been shown that an expensive Indian Medical Service officer is by no means a *sine qua non*; that assistant surgeons and private practitioners who have been taken on in the place of Indian Medical Service officers have done their work efficiently and demonstrated that a specially trained service of European doctors is not at all essential to the medical administration of the country. No doubt credit is due to many elderly men who have come forward to fill gaps at a time of emergency; and there are many assistant surgeons who have worked hard and carried on the administration. But it is quite certain that only the stress of a war of such great magnitude would justify the depletion of highly skilled officers which has taken place, and that there would be no justification whatsoever for so thinning the ranks of the Indian Medical Service in civil employ that ordinary frontier campaigns on a somewhat large scale would leave only the same residuum of Indian Medical Service officers over the country as has been left during this war. Experiences as to the method in which substitutes have worked do not form the subject of formal official reports, and one hears a great deal more in informal conversation of the inconveniences experienced by the absence of highly-

trained medical officers than can be gathered from a perusal of official papers and periodical reports. The reporting officers have naturally not been anxious to take too strict a view of the character of the work done by these substitutes. But there can be no question of the general medical administrative work of the country having been much below the standard expected of Indian Medical Service officers. Naturally enough, serious scandals or a complete breakdown are not likely to follow immediately on such changes. The machine is working and it is carried on, though those guiding it may be less skilled and less energetic. But there is going on a steady process of deterioration which will only become fully manifest when the officers of superior skill come back to their places and resume the conduct of affairs. It takes time before the defects of a *locum tenens* come to light and the instances in which there are glaring failures are necessarily few. Even so, however, in particular districts it has been obvious that the administration of jails and hospitals has suffered very greatly and the experience is not such as to encourage any repetition of the experiment which the war has forced upon us. If there has been no manifest breakdown, there has clearly been no progress at all. In some Provinces, marked failure has occurred in specific instances, and though none such has actually been reported from Burma, the Local Government is anxious that the present strain should not be continued longer than can be helped, and desires that the Indian Medical Service elements in its medical services should not only be restored, but increased beyond the pre-war strength, a recommendation regarding which was before the Government of India prior to the outbreak of war. A year or two hence, it will probably be possible to confirm, by actual facts, the opinion here given; but the full state of deterioration will not come to light until competent medical administrators have got to work again in the districts which have, for the past two or three years, been under the charge of temporary substitutes. In the meantime, everybody concerned has been making the best of what was inevitable; and on no account should the precedent of this war, in the direction of the depletion of the medical services, be repeated.

Enclosure No. 2.

Note on the proposed reorganization of the Medical Services in India, prepared by Lieutenant-Colonels Entrican, Barry, and Dee, I.M.S.

The necessity for some measure of reform is obvious; and four schemes, A, B, C and D, have been submitted to us for consideration.

All these schemes have this in common, that they substitute for the present homogeneous service with one portal of entrance, a service or services made up of heterogeneous elements with many portals of admission.

We would like to point out that no reasons have been adduced, in justification of the drastic changes now proposed. It has not been shown wherein the Indian Medical Service has failed to justify its existence. The defects which the war has brought into prominence were perfectly well known and frequently pointed out long before August 1914, but the policy of starving the military branch of the Indian Medical Service, prevented anything being done to remedy them. The various schemes for reform assume, without any attempt to prove, that the organization of the Indian Medical Service is in such a hopeless state of disrepair that there is nothing left but to scrap it. We strongly dissent from this assumption, and consider that no case has been made out to justify such a belief.

The present Indian Medical Service could easily be made second to none as a military medical service, with a war reserve of officers superior to that of any other army or country, because this reserve has, in its ordinary duties, administrative and professional experience such as the ordinary medical practitioners who in all countries form the bulk of the medical reserve do not and cannot have. Such a service could be at once constituted by carrying out the reforms outlined below, and we believe this would be simpler, easier and less expensive than the adoption of any

of the proposed schemes or of any variant of them.

Before discussing the scope and direction of this reorganization we will briefly state our objections to the schemes labelled A, B, C and D.

CRITICISM OF SCHEME A.

This is said to be a scheme for the formation of a unified military service. It is not easy to see where unification comes in; the Indian Medical Service is abolished, but a new service is created to take its place (the Auxiliary Corps). Moreover, a second new service, the Civil Medical Service, is suggested to replace the Indian Medical Service in civil employment. As regards the Military services, there still remain two distinct services, one for British and the other for Indian troops. Therefore, any objection that there may be to the present dual services will apply with equal force to the proposed arrangement.

The auxiliary corps.

The civil medical service, with its superior opportunities for professional work and with its prospects of private practice, must present a great attraction to both Anglo-Indian and Indian medical men; and it will be difficult to obtain recruits of a desirable stamp for this Corps unless the pay and prospects offered are considerably more attractive than those of the proposed civil medical service. The medical service of the Indian army would, therefore, be officered by men of inferior capacity.

This being so, it will follow that the more responsible military medical appointments, both administrative and executive, will have to be entrusted to officers of the European services; the result will be discontent, which will re-act on recruiting, making an already unsatisfactory state of affairs still worse. In short, the scheme aims at substituting for a service which in the past has been efficient, and could be made so again, a new service, which must from its birth be unpopular and more or less inefficient.

The civil medical service and its recruitment.—The scheme introduces a new and untried principle, in seconding into civil employ, for short periods, European medical officers who in very many cases will have little or no knowledge of Indian conditions. This will probably meet with opposition from Local Governments, and is practically certain to result in friction inside the service itself. The whole scheme appears to us unworkable and unfair to the majority of the Indian Medical Service.

As regards the disposal of the present Indian Medical Service officers in military employ, they are offered the choice, if of less than fifteen years' service, of electing to be absorbed into the Royal Army Medical Corps; or of standing out with officers of over fifteen years' service, and being seconded with the Royal Army Medical Corps. They entered the service under certain definite promises from the Government; and to reduce those who do not elect to, or cannot join, the Royal Army Medical Corps, to remnants of an abolished service would constitute a breach of faith on the part of the Government.

As regards what are called the "Points of the Scheme."

1. The scheme is not a unification, in that instead of unifying the services, it merely abolishes one to replace it by another, which must be inferior, in practice.

2. This adequate reserve can be much better provided for by a reorganized Indian Medical Service than by any proposal embodied in scheme A.

3. This alleged disadvantage applies to all services under the Government of India. In the past, one of the chief grievances of the Indian Medical Service has been the difficulty of obtaining leave. With improved organization, officers may be depended on to take all the leave necessary to keep them efficient.

While the Indian Medical Service is undoubtedly in need of reorganization, the abolition of the service and the substitution for it of two services, one of which will be inferior and both discontented, does not appear to be a remedy.

CRITICISM OF SCHEME B.

This scheme comprises a series of notes regarding the lines on which any organization of the medical services in India should take place, and the ideas conveyed by the author have been carefully weighed, and have been taken into consideration in the formulation of the following scheme of reorganization.

It may be again emphasized that no possible advantage can be gained by introducing officers of a different Corps for short periods into the Indian Medical Service. On the other hand, the disadvantages of such an arrangement are obvious. These officers being attached to the Indian Medical Service, for very limited periods, would have no inducement to identify themselves with the permanent service, and by not casting in their lot with this service, they would fail to amalgamate with, and would form an alien element in it.

The objections to the suggestion in paragraph 24, page 6, for the elimination of the Royal Army Medical Corps from the Medical Service in India are:—

- (i) The scheme would probably not be accepted by the War Office;
- (ii) If it were adopted it would seriously hinder recruitment for the Indian Medical Service, because it would so increase the preponderance of the military side of the Indian Medical Service that no man on entry, could look forward with certainty to obtaining civil employment, and this is the main inducement which brings men into the Indian Medical Service;
- (iii) The Government of India would be called upon to provide a European medical reserve for the British army in India, which reserve is under the present system provided for by the United Kingdom.

CRITICISM OF SCHEME C.

The executive officers of this new Indian Military Medical Service are to be drawn from different classes by four different methods of recruitment:—

- (1) Open competition by examinations held in the United Kingdom.
- (2) Seconded officers of the Royal Army Medical Corps.
- (3) Permanently transferred officers of the Royal Army Medical Corps.
- (4) Promoted assistant surgeons.

The author rightly insists on the maintenance of a very high standard of attainments, but it is to us inconceivable that a standard in any way equal to that of former years could be maintained by such a method of recruitment. The size of this Corps, estimated at 900 to 1,000, greatly diminishes the individual officer's chance of obtaining a civil appointment. This has always been the great inducement to enter the Indian Medical Service, and the principal factor in maintaining a high standard of entrance. By virtually doing away with it (for no man will enter merely on the off-chance of getting civil employment) you destroy the magnet which formerly attracted the pick of the medical schools. This scheme, we feel convinced, would ensure a rapid and wholesale deterioration in the personnel of the military medical service. Similar considerations apply to the higher grade executive officers of the proposed civil service.

Here again there are four different classes recruited from four different sources:—

- Indian Medical Corps.
- Qualified Europeans or Anglo-Indians.
- Promoted Indian civil assistant surgeons.
- Promoted Indian military assistant surgeons.

This mosaic of officers is to be of one grade only and it requires little prophetic vision to foresee the result.

We consider the ideal laid down in paragraph 14, that all members of the military medical service should be capable of working in every branch of the service in peace or war, is altogether utopian. The Secretary of State for India has insisted that Indians

must be admitted in increasing numbers to the medical services, but we feel quite sure that a service in which Indians would find themselves at work in or even in command of British hospitals would be very unpopular with them.

The difficulty would almost certainly end in the relegation of Indian officers to Indian and European officers to British hospitals, and the ideal be farther off than ever.

This scheme contains many excellent suggestions but is in our opinion altogether vitiated by the attempt to fuse different professional and social strata into one uniform mass. The result would, we believe, be disastrous to all concerned, and far from leading to higher scientific and professional standards would inevitably degrade them.

SCHEME D.

The objections to this scheme are similar to those already enumerated when referring to scheme A, B and C and may be very briefly recapitulated. The military branch would have a very small outlet into civil employment, and this inducement would cease to operate in recruiting. The men who formerly came into the Indian Medical Service would now go direct into the permanent civil service, *vide* (b). The military branch would attract only very second-rate men.

The idea of a combined station hospital would be found unworkable for reasons already given. India could not supply the large European reserve required, and if a reserve was instituted in the United Kingdom, its members would not fit into any combined hospital system.

SUGGESTED REORGANIZATION OF THE INDIAN MEDICAL SERVICE.

We are of opinion that the present dual system with adequate reorganization of the Indian Medical Service will be found simpler, better and cheaper than any of the proposed schemes, and we will now attempt to outline (for lack of the necessary data forbid us doing anything more) the changes we deem necessary:—

I.—*The formation of an Indian Medical Corps, complete in every respect, officered by the Indian Medical Service, with a proportion of European sisters.*

The sub-assistant surgeons should be given the rank, status and title of Indian officers. The enlisted men should provide for all duties,—clerks, compounders, store-keepers, nursing orderlies, ambulance and transport men, cooks, bhisties and sweepers.

The terms of enlistment should be such as to produce a large and efficient reserve which should be called up periodically for training.

Non-commissioned officers should as far as possible be provided by the promotion of enlisted men, and should be eligible for clerkships, compounderships, etc., if they attain the necessary standard of skill and education. The corps should be regularly mobilized and instructed in field duties. It should ordinarily have sufficient transport, under its own command, to provide for the instruction of its establishment. The whole of the superior personnel of the corps should go through occasional instructional courses at the Indian Medical Corps College. Everything possible should be done to foster *esprit de corps*.

A feature of all the other schemes is a very large increase in the officer personnel. We dissent from this, preferring as our ideal a comparatively small but perfectly trained peace establishment, capable of rapid and easy expansion by the incorporation of trained reserves in time of war.

A strength of three officers per 1,000 men in military employ is far in excess of real peace requirements and men would spend half their time loafing, at the expense of the state and their own demobilization. Would it not be far better to employ them in some useful civil work?

The argument that a much higher standard is now required for care of the sick soldier, and that therefore a much larger number of officers is required, we consider fallacious. The disadvantage which the sick

Indian soldier formerly suffered from was not due to the absence of professional skill, but to the almost complete lack of skilled nursing and attendance, as well as miserably defective accommodation and equipment of all kinds. If these defects are remedied by the formation of the corps above outlined, there will be no need for any great increase in officer personnel. Probably the introduction of the station hospital system will obviate the necessity for any increase in the proportion of officers employed.

An additional argument against an overgrown military branch is the detrimental effect it would have on recruiting because transfers to civil would be more difficult and longer delayed. This Indian Medical Corps should be completely independent, under the officer commanding the station and the Assistant Director of Medical Services.

The senior medical officer should be done away with. This office with its ill-defined duties and responsibilities is a fruitful cause of friction between the two military medical services. It is not found necessary to have a "senior infantry officer" to intervene between the officer commanding the station and the commandants of British and Indian infantry regiments.

II.—*Relations of this Indian Medical Corps with the Civil Department.*

The present water-tight compartments into which the Civil and Military branches of the Indian Medical Service are divided should be done away with and men freely transferred from one service to the other. No man ought to be allowed to spend all his time in one branch or in the other. All officers would, as at present, join the military branch. Those who elect to go into civil employment would do so as early as possible after having passed their language and "promotion to Captain" examination. Their military service would not, however, cease. They would, up to 20 years' service be recalled periodically for such training as is considered necessary by the army authorities—spending the time partly at the training college and partly at station hospitals. They would be compelled to pass all military examinations for promotion. Failure to do so would involve retention in military duty until the examination was passed.

In the case of some of the highly specialized civil appointments, it might perhaps be advisable to do away with the liability to military duty at an earlier date than 20 years.

Officers who elect to remain in the military branch should be compelled to do one-fourth of their service up to 20 years in civil employment. This period should not be taken continuously but in instalments not exceeding two years at a time. After 20 years' service they would remain permanently in military employment and all military administrative appointments should be filled from their ranks.

Civil administrative appointments should be similarly reserved for men who elect to remain permanently in civil, but up to 20 years the services should be freely interchangeable on something like the above lines. Men from the military branch could be largely utilized to replace men on long leave in the Civil Department. Competition should be freely open to all British subjects of whatever race, but with the proviso that candidates must have spent at least three years at some recognized medical school in the United Kingdom, or two years in the United Kingdom with one on the continent, and should be in possession of a British qualification. At present and for many years to come, the Indian Medical Schools will not be able to supply the professional and social training necessary to fit the Indian for his position as a member of the Indian Medical Service. The medical profession in India is still in its childhood and must for some time continue to look for guidance and teaching to men trained in Europe.

It is no doubt a hardship that Indians who cannot afford to go to Europe should be debarred from entering the Indian Medical Service, but in the future interests of the medical profession in India, which are far more important than those of a few individuals, this course is absolutely necessary.

The hardship could be mitigated if not altogether removed, by the institution of scholarships, for selected students from the Indian Medical Colleges, which would enable them to defray the expenses of residence in Europe.

III.—Entrance into and conditions of service.

The standard of the Indian Medical Service was formerly the highest of any large public medical service in the world, and we are strongly of opinion that such a standard can be regained and retained only by restricting entrance into it to one portal, *i.e.*, open competition in the United Kingdom. The examination should be made a thoroughly practical test of a man's knowledge, skill and character. Mere book knowledge should count little. For the immediate needs of the service, it may be necessary to offer a number of commissions to men who have served in the war, but this should be looked on only as a temporary expedient, and recruitment allowed to return to its normal course as soon as possible.

In order however to get a good class of recruits, the attractions of the service, of late years sadly diminished, must be greatly increased.

The whole subject is exhaustively dealt with in the memorandum submitted to the Royal Commission on the Public Services in India, by the British Medical Association on April 10th, 1914, and we need only outline the chief requirements:—

(a) A substantial increase of pay all round, and we consider that as far as possible this should be consolidated. The system of pay *plus* allowances means considerable loss during privilege leave and furlough.

(b) An increase in cadre sufficient to allow all leave earned to be taken. The difficulty of getting leave has, for many years, been a very real cause of discontent. Study leave should be compulsory to the extent of one year in 20, and should count as duty in regard to pay, pension and ordinary leave.

(c) *Pensions*.—We suggest the following slight change in the rules. At present the pension increases by £20 yearly between 20 and 25 years and by £40 yearly between 25 and 30 years' service.

This arrangement should be reversed and the pension increased by £40 yearly during the quinquennium 20 to 25 and by £20 yearly between 25 and 30.

An officer would thus be able to retire on £600 a year at 25 years' service, but his full pension at 30 years would be the same as at present, *i.e.*, £700.

This would be a considerable inducement for men to go at 25 years and keep the service younger. Administrative rank would consequently be reached at an earlier age, and few will deny the advantages of this.

(d) The Director of Medical Services, India, should be appointed alternately from the British and Indian services and not, as now, exclusively from the former. The Director-General, Indian Medical Service, should have direct access to the Government of India, and similarly the Provincial heads of the Medical Department should have direct access to their Local Governments.

(e) Restrictions to private practice should be abolished. This right was formerly one of the chief causes of the popularity of the service. It seems a shortsighted policy to do any thing to prejudice a factor in recruiting which costs Government nothing, more especially in view of the fact that opportunities for private practice have of late years greatly diminished.

(f) An Indian Military Medical College should be founded. To this, all newly appointed officers should be sent on arrival. This college would also hold instructional courses for all ranks.

(g) It is desirable that greater facilities be given for scientific research work, and that this branch of the service be greatly increased. At the same time we do not think these appointments should be confined to the Indian Medical Service. They should be open to anyone, whether in or out of Government service, the only test being ability.

IV.—Reserves.

As already explained the bulk of the Indian Medical Service in civil employment would form a trained reserve, but more than this is necessary.

All medical officers of whatever rank serving in the Civil Department of the Indian or Provincial Governments should undergo, as one of the conditions of their appointment, a military training, and be liable for military duty up to 20 years' service. An additional reserve should also be formed from European, Anglo-Indian and Indian medical men engaged in private practice. Some scheme might, we think, be elaborated by which these men should receive paid appointments, commensurate with their qualifications on the staffs of the larger hospitals, and in return for such appointments undertake liability to some degree of military training in peace and service in war.

Letter No. 475—5 X-4, dated the 13th February, 1918, from the Secretary to the Government of Burma, to the Secretary to the Government of India, Home Department.

I am directed to acknowledge the receipt of Mr. Marris's letter, No. 680-C., dated the 6th December 1917, on the subject of increasing the remuneration of the Indian Medical Service, and to submit the following reply. It seems impossible to consider the subject properly entirely apart from the general question of recruitment for the Indian Medical Service. The letter under reply implies that the contemplated increase is necessitated by difficulties in recruitment. The normal system of recruitment has been so dislocated, both before the war and during its continuance, that it is impossible to lay down any system of remuneration with much confidence until a decision has been arrived at as to the future of the Indian Medical Service, its recruitment, its duties and its constitution; as to the relation that it will bear to the army on the one side and the civil administrations on the other; and, lastly, as to the extent to which the service will either be thrown open to Indians or entry into it so devised that Indians are likely to secure an entrance into it in largely increased numbers.

2. Sir Reginald Craddock is convinced, from all that he has heard, both in India and in England, as to the future prospects of the Indian Medical Service, that radical changes in its constitution are necessary, and that no satisfactory scheme of remuneration can be laid down for that service until its new constitution has been completely decided. In these circumstances, I am to put forward some observations and proposals regarding

the system of recruitment that should be followed, if the traditions of the service are to be maintained, if it is to attract to itself the cream of the medical profession, and if it is to give satisfaction both in respect of the public duties which are required of it, and in regard to the services which it renders to the European community in India. His Honour desires to lay great emphasis on the fact that the Indian Medical Service in India, whether it retains its connection with the army or whether it is reconstituted as a purely civil medical service, is on a totally distinct plane from all other services in India *vis-à-vis* the European. So long as the service remains select and in due proportion to the needs of Europeans in India, the Indian, as such, has no claim to absorb to himself posts in the service which are considered necessary for the requirements of Europeans. The whole system of Government in India is modified by the necessity of giving some recognition to the likes and dislikes of various sections of the community, and it would be grossly unfair to lay down or accept any policy which implied that the prejudices of Europeans were the only prejudices in this country which might be treated with contempt and disregard. People all the world over, when it comes to the intimate relations between patient and doctor, have a strong preference for treatment by doctors of their own race, and that the same should be the case with Europeans in India reflects no stigma whatever upon the ability or capacity of Indian doctors. No Indian need be compelled to accept

treatment from the European doctor unless he chooses, and the same rule should be applicable to Europeans. This principle has frequently been ignored, most frequently indeed by those Europeans who are so highly placed that there is no risk whatever of their being forced to resort to Indian doctors for themselves, their wives and their families because no European is available or can be procured except at prohibitive cost. His Honour would lay great stress on this differentiation between the medical services as distinct from others, for it is a differentiation which is known to everybody but is never given the weight that it deserves because to give such weight is supposed to indicate a reflection upon the capacities of Indian members of the medical profession. It has already been stated that a preference in favour of a doctor of one's own race conveys no stigma upon doctors of other races. As long as the competition for the Indian Medical Service is open to all comers, there is no means of ensuring that the proportion of European doctors in that service shall conform to the requirements of the European Services. Any failure to conform to those requirements will react most unfavourably on the popularity of those services, and greatly discourage prospective candidates desirous of entering them.

3. The scheme I am now to put forward to the Government of India for their consideration is that the medical work of the Army should, in peace time, be carried out by officers of the Royal Army Medical Corps. The officers of this Corps deputed to India for a tour of service of not less than five years' duration, could become just as capable of treating Indian soldiers as are the junior officers of the Indian Medical Service who are now sent out. These officers of the Royal Army Medical Corps might be permitted to apply for transfer to the Indian Medical Service, which should be a purely civil service, retaining, however, its time-honoured name. Candidates from the Royal Army Medical Corps desiring to join the Indian Medical Service as a civil medical service, would be required to have shown aptitude for civil duties, to have passed a sufficiently severe language examination, and to be certified as thoroughly fit, professionally and otherwise, for a medical career in India. This would insure,—

- (1) that the European element in the Indian Medical Service would be recruited from the same material as supplied the medical department of the army;
- (2) that every member of the Indian Medical Service would have passed at least five years—or it might be even longer—in military medical work and thereby acquired experience which would afterwards stand him in good stead if a war should necessitate volunteers from the civil medical service to the army.

The doctors transferred to the Indian Medical Service, now wholly a civil service, would, of course, drop their military rank. They would be paid according to a scale of pay fixed with the object of providing sufficient remuneration for the duties required of them, and, in the event of war requiring them to volunteer for service again in the army, they would draw the pay which they had last drawn in civil life. This plan would secure a very suitable material for the European branch of the Indian Medical Service; it would create a reserve in India of medical officers to be drawn upon if the Empire should require them (just as civilian doctors have been drawn upon for the Royal Army Medical Corps, in the present war); and incidentally it would add some attraction to doctors entering the Royal Army Medical Corps because some of them stand a good chance of being selected for the Indian Medical Service after they have put in a suitable period of service with the army. Such officers will have been subjected to discipline while serving in the Royal Army Medical Corps, and will be no worse qualified for civil appointments than are their brethren of the Indian Medical Service when they quit military for civil duties.

4. With respect to the Indian element in the Indian Medical Service, this should be recruited by two methods,—

- (1) from Indians who have attained high qualifications in the United Kingdom; and
- (2) by promotion to the best assistant surgeons in India.

The number of appointments open to the Indian section of the Indian Medical Service can be laid down with reference to the duties that may be required of them. It will no doubt be possible to offer them a few minor civil surgeoncies, though these should be very restricted in numbers because of the necessity for providing the European servants of Government with doctors of their own race. But they could be given professorships and the charge of hospitals and some of the jails. In the large stations, where civil surgeons are overworked, provision could be made for joint civil surgeoncies, one of the posts being held by an Indian and one by a European, the division of the duties of the district or station between them being determined by the administrative medical officer in charge of the province. The Indian members of the service would generally be on terms of equality with the other members, and they would be eligible for the administrative posts if they could satisfy tests by which selection to such posts was determined. Their relative seniority, as compared with the European members recruited from the Royal Army Medical Corps, would be calculated on the basis that every entrant from the Royal Army Medical Corps was credited with five years' service, representing his tour of service in India.

5. It is not necessary at this juncture to enter into the question of the salaries of the Indian Medical Service reconstituted as here proposed; but Sir Reginald Cradock considers that the salaries of Indian Medical Service officers should be materially raised, and that their private practice should be limited to officers in Government service, their wives and families, and, as regards non-officials, to consulting practice only. Special permission to treat non-officials might be accorded in cases where there are European non-officials and no other European practitioner.

6. It is understood that the probable result of the experience gained during the war will be to abolish the system of regimental doctors in the Indian army, and to substitute for it the station hospital system. This arrangement would greatly facilitate the scheme which is now advocated. It would save the conflicting claims between officers of the Royal Army Medical Corps and Indian Medical Service which now constantly give rise to friction, and it would provide India with a service of civil doctors equal in skill and professional qualifications to those who have hitherto adorned the Indian Medical Service. This system would also control the entry of Indians into the Indian Medical Service with reference to the consideration that a European minimum is necessary for the European services.

7. Advertising specially to the case of Burma, His Honour desires to take this opportunity of placing emphasis upon the principle that the prescriptions of the Public Services Commission in regard to the employment of Indians in the services in their application to Burma must be modified by the facts that the people who have to be considered in Burma are Burmans and not Indians, and that the ratio of Burmans to Europeans in the public services in Burma must be determined not by the most suitable ratio of Indians to Europeans in India, but by the appropriate ratio of Burmans to Europeans in Burma itself. It is quite possible that in years to come the relative fitness of Burmans for posts now held by Europeans will be equal to, or even greater than, the relative fitness of Indians for such posts in India proper; but in the meantime, and until that fitness is demonstrated, it will serve no good purpose whatsoever either to pour Burmans into the public services in a ratio quite beyond their present capacity, or to inundate Burma by an influx of Indians in order to preserve the ratio between Europeans and non-Europeans found expedient in India. The Burmans have no desire for such an influx, and its most probable result would be to impede rather than to facilitate the progress of Burmans. With every desire to encourage Burmans, to provide for their better qualification and training, and to employ them whenever and wherever their fitness justifies such employment, His Honour has no desire to push them on in advance of such fitness merely to secure a statistical resemblance to the composition of the services in India proper.

8. Returning now to the immediate proposals on which opinion is invited, it is to be considered whether there exists so urgent a demand for improving the pay of the Indian Medical Service that it is impossible to wait until the end of the war, when the future of the Indian Medical Service as a service will have to be decided, and when

a reconstitution of that service, either by the methods outlined above or in some other manner, may be necessary. The Public Services Commission considered the case so urgent, that they recommended that a sum equivalent to $12\frac{1}{2}$ per cent. of the emoluments of the service should be apportioned between the posts held by its members, leaving for the present consideration of the further improvements required in order to make that service attractive and to put it on a level with other public services in India.

9. The subject of the reference is one which came constantly before Sir Reginald Craddock when Home Member of the Governor General's Council. His Honour was certainly inclined to the opinion that, with so many of the officers of the Indian Medical Service away on military duty, the concession here proposed would merely benefit those few members of the service who could not be spared for military duty, and who held, in the great majority of cases, the most lucrative posts which the service, under present conditions, offers. But the protraction of the war far beyond all expectations has postponed consideration of the conditions and emoluments of the service for so long, that the case for an immediate concession has been greatly strengthened. Although it is true that such members of the service as remain on civil duty are occupying most of the higher and more lucrative posts, it has to be said against this that in almost all cases these officers are performing, sometimes double, and in all cases more than, the ordinary duties usually attached to those posts. Furthermore, it would be a source of much satisfaction to all those officers who have been recalled to military duty if they can be certain that when they return to civil employment they will receive some increase of pay. Although from the conditions of their service Indian Medical Service officers in civil employ were obliged to return to the Army and accept the military pay of their rank, *plus* such staff allowance as the posts they held might entitle them to, in a large number of cases this obligation meant that they had to suffer a reduction in their emoluments, in addition to the loss sustained by the complete cessation of their private practice. It is currently reported that many of these officers are dissatisfied with the promotion and employment that they have been given while on active service. Many of them who are professionally most highly qualified have had to accept comparatively humble duties on the ground that their brethren of the Royal Army Medical Corps had greater experience of the duties of army doctors. Consequently some Indian Medical Service officers have been relegated to subordinate posts where they have had to work under officers of the Royal Army Medical Corps considerably junior to them in their profession. In these circumstances, many Indian Medical Service officers are intending, as soon as the war is over and they have satisfied the call of patriotism, to give up the service and start afresh in England. His Honour is not in a position to say how far this feeling is general and to what extent such a course will be adopted by members of the service : but, from what has been spoken and written on the subject, it is considered highly probable that the number of officers who may wish to resign will be so large as to cause the greatest possible inconvenience. It is open to the Government of India subject to the sanction of the Secretary of State to continue an officer in employment should it be necessary for the good of the service. Such action is, however, contemplated in special cases only, and the exercise of the power simultaneously in a number of cases would be a cause of widespread discontent. This would be most regrettable at such a juncture, and it is important, therefore, that the service should not feel that the Government has turned a deaf ear to grievances and petitions which are of many years' standing.

10. For these reasons, His Honour is prepared to recommend that the proposal of the Commission to distribute the equivalent of $12\frac{1}{2}$ per cent. of the emoluments of the service among its members should receive early effect. The civil surgeons of the Indian Medical Service are at present much under-paid. Their emoluments have not risen *pari passu* with those of other services; and whatever consideration, in fixing those emoluments, had been given to the fact that doctors were allowed to have private practice, has lost most of its weight by the fact that such practice has very greatly diminished. This diminution has been due partly to

the competition of private practitioners, but also very greatly to the fact that owing to the increase in the number of European officers in the services, to the great increase in the number of hospitals, as well as to large calls made upon them for sanitary supervision and many other miscellaneous duties, the time left over for private practice has been much curtailed.

11. It is understood that neither the Commission nor the Government of India had any desire to include in this reference the pay of the various ranks of Indian Medical Service officers serving in military posts, and that the proposed concession relates only to the pay of civil appointments. On this understanding, the best way of distributing this concession will be to take the salaries of all civil posts normally held by the Indian Medical Service other than those of administrative rank, to compute $12\frac{1}{2}$ per cent. on this sum, and to apportion that sum among those posts in such manner as may seem most advisable.

12. One method of apportionment which has been considered is based on the fact that the pay of professional, teaching and special appointments, has, in most cases, been fixed at a comparatively recent date, account having been taken of the extra cost of living and other considerations affecting the emoluments received, while in many instances special allowances have been given for loss of private practice. The amount to be apportioned to posts of this class might be less than the sum to be apportioned to the appointments of civil surgeon or the superintendent of a jail or a lunatic asylum. But apart from the practical difficulties in making an apportionment by this method, the salaries of recent special appointments have been fixed partly with reference to the scales of pay of the normal appointments of the Indian Medical Service, and discrimination on these lines is not altogether justified. An alternative method of apportionment is suggested by the wide interval in the scale between the salary of a major after three years' service and a lieutenant-colonel. This interval is based on purely military considerations, and would not be justified solely by the civil duties normally performed by these two classes of officers. Larger concessions are needed by officers of the Indian Medical Service below the rank of lieutenant-colonel than by those officers who have attained this rank, and the value of the proposed increase will be enhanced if granted where it is most needed.

13. In applying this method in present circumstances to the Indian Medical Service in Burma, it is found that on account of the war the majority of the 32 civil posts held by officers other than those of administrative rank are not at present filled by officers of the Indian Medical Service. If, however, the distribution is based on that which obtained at the beginning of 1914, after making probable assumptions for the three appointments created since that date the normal distribution would be 9 lieutenant-colonels, 15 majors and 8 captains. Their total salaries calculated on the prescribed scales would amount to Rs. 31,665 per mensem. Adding exchange compensation allowance, where admissible, at current rates, the amount on which the concession is to be based is Rs. 32,563 per mensem. The amount available for apportionment at $12\frac{1}{2}$ per cent. of this sum is Rs. 4,070 per mensem. An increase of Rs. 75 per mensem to lieutenant-colonels, and of Rs. 150 per mensem to all officers below the rank of lieutenant-colonel, would require Rs. 4,125, a sum slightly in excess of the $12\frac{1}{2}$ per cent. allowance recommended by the Commission. It is improbable that this sum would actually be attained before the contemplated reorganization of the service is effected, as it will be difficult to fill the whole of the 32 vacancies with Indian Medical Service officers for some time after the war. These increases while still maintaining a wide difference between the emoluments of a lieutenant-colonel and those of officers of lower rank reduce that difference to an amount more in consonance with the civil duties performed. They are accordingly recommended as providing the most satisfactory apportionment of the allowance which can be effected in Burma. At the same time the Lieutenant-Governor desires to lay some emphasis on the fact that this concession, if made, should not be allowed to prejudice in either direction the scale of emoluments which is ultimately to be determined, when the reorganization of the medical service, whether on military or civil lines, comes to be undertaken.

Letter No. 89-M. T., dated the 26th February, 1919, from the Secretary to the Government of Bihar and Orissa, Municipal Department, Medical Branch, to the Secretary, Medical Services Committee.

I am directed to refer to your letter No. 9—3, dated the 17th February 1919.

2. In reply, I am to express regret that the Local Government have not found it possible within the time at their disposal to prepare a full and considered statement on the subject-matter contained in the rough material forwarded to them by the Committee. The Lieutenant-Governor in Council desires, therefore, to reserve his considered opinion until a later date. In order, however, to meet the wishes of the Committee, so far as is possible, I am to forward fifteen copies of a note by the Honourable Member in charge of the Medical Department (enclosure), which represents the general views on the subject which His Honour in Council provisionally holds.

Enclosure.

HON'BLE MR. MAUDE'S NOTE.

This Committee was constituted by the Government of India in a letter dated 15th January, 1919, to the Director-General, Indian Medical Service. The Committee were to formulate a general scheme for the future organization of the medical services in India.

In a letter dated 28th January and received by us on the 31st January, the Committee formulated six very vague matters to be considered, one of which related to medical stores.

On the 6th February we received a list of questions and a scheme called "A," and on the 9th February we received two more schemes called "C" and "D," professing to be schemes for a unified medical service in India.

The Committee will arrive on the morning of the 27th February. They want to examine between 11 A.M. and 2 P.M., on the 28th February, the Inspector-General of Civil Hospitals and some one who is to lay before them the views of the Local Government, and they will also examine other officers. We have selected the following:—

1. Col. Sunder.
2. Col. Murray.
3. Major Thornely.
4. Dr. Livesey.
5. Dr. Thompson of Dhanbad.
6. Rai Bahadur Tarak Nath Mitra, Civil Surgeon, Arrah.
7. Mr. Pramananda Das.

There was a little delay in settling the witnesses, and they will not have received their papers till the 19th or 20th instant. The Inspector-General of Civil Hospitals has replied to the questions of the Committee in his letter of 12th February, and has further commented on schemes C and D in his letter of the 13th February. I regret that in the absence of a properly considered opinion not only of the Inspector-General of Civil Hospitals but also of the medical officers of the province generally and in the absence also of any sufficiently defined points on which to form opinions, I am unable to suggest any constructive Government ideas, and all that can be done is to express a few more obvious criticisms on the three schemes A, C and D which have been sent us.

The object of the Committee is apparently to formulate a scheme for a unified Indian service of medical men, but schemes C and D are neither of them in any sense unified, but merely perpetuate the present dual existence, *viz.*, Royal Army Medical Corps alongside of Indian Medical Service with slightly altered conditions. Scheme C frankly admits that it is not a unified scheme at all, while scheme D while professing to create a single Indian Army Medical Corps makes that corps consist to the extent of 10 per cent. of Royal Army Medical Corps men deputed from home to Indian service for a period of five years. Scheme B is of the same nature, as the service would consist of roughly 1,000 Indian Medical Service officers and 320 Royal Army Medical Corps officers, also deputed for five years to India.

Scheme A is therefore the only one which has any pretence of being a unified service scheme, and schemes B, C and D need not be considered at all.

Scheme A purports to be a genuine unification but in reality it is not completely so. It divides the Indian Medical Service into (1) a military service, (2) a civil service. The military service, so far as officers are concerned, is the Royal Army Medical Corps pure and simple and there is unification so far, because the Indian Medical Service element is got rid of. But when we come to the civil side we find the old idea of drafting 10 per cent. of the cadre from the Royal Army Medical Corps on deputation to India in 5-year batches. There is therefore no real unification on the civil side. This seems to be the main objection to the scheme, but the following points seem also liable to criticism:—

- (1) The auxiliary corps of the military Royal Army Medical Corps is to consist of Indians and Anglo-Indians who are to be recruited in the manner in which the Indian Medical Service members are now recruited, *i.e.*, by a stiff competitive examination in England. This will probably fail. Even the Indian Medical Service cannot find recruits under present conditions, and there is no likelihood therefore that a service which, as Colonel Bell points out, will be on an inferior footing, will find recruits where the Indian Medical Service fails to find them. As the auxiliary service is to be entirely Indian and Anglo-Indian, it will be a blank from the beginning if it is to be recruited in the same way as the Indian Medical Service is now recruited, especially as the members will be liable to general service all over the world.
- (2) The idea of combined hospitals for European and Indian troops is not supported by any arguments. I believe there have been some such hospitals during the war but that their working has not been good, and the general opinion, which I fully share, seems to be that they would be neither economical nor successful in any way.
- (3) I have grave doubts whether the introduction of short term consulting surgeons and physicians from Home, who would tour the military hospitals, would work without friction. They would be totally ignorant of the conditions, not to mention the peculiar diseases of this country and if they interfered in any way, would be told in plain language that they know nothing about the country. However, as under the scheme they would only visit military hospitals, it does not affect the civil view deeply. (I see Colonel Bell gives them a half-hearted approval.)
- (4) The proposed civil medical service is simply the present Indian Medical Service considerably extended but at the same time watered down by an admixture for no apparent reason of a 10 per cent. blending of Royal Army Medical Corps men. The members are to be recruited as the Indian Medical Service men are now recruited, *i.e.*, by competitive examination after a qualifying test in England. They will have no military rank except when on temporary deputation to military duty in military (station) hospitals. The Indian Medical Service cannot get men now, *a fortiori* it will not get them as a civil medical service under the proposed conditions unless the pay is very much increased, a point on which the scheme is completely silent.
- (5) It is proposed that all civil medical service men should be deputed on arrival and again after every five years to do six months' duty at a station hospital under the military service (Royal Army Medical Corps) men. This would destroy the last remnants of chance

of recruiting for the civil medical service. It would be more to the point if all the military service were deputed on arrival and again after every five years to a six months' course at one of the big civil hospitals.

- (6) It is proposed that there should be five grades in the civil medical service corresponding to the ranks of lieutenant, captain, major, lieutenant-colonel with a presumably administrative grade at the top. Promotion to the lieutenant-colonel grade is to be by selection. This is the existing military system more or less; but it seems doubtful if it is suitable for civil services. There should be more grades so as to obviate too long service in one grade, especially in the lower grades. Probably a time-scale would be more suitable with two selection grades at the top. The recommendations of the Public Services Commission do not help us in the medical upper services as they practically recommend that things should be left for decision by the light of the war which began after they had left India.

There seem to be two main objects which have to be achieved by any scheme which may be put forward, viz.,—

- (1) The provision of a sufficient reserve to meet war requirements.
- (2) The avoidance of mutual antagonism between military doctors and civil doctors in the officer personnel.

The first is a mere matter of money. Local Governments must decide how many medical men they need for civil purposes in the higher service and are prepared to pay for. If the number so guaranteed is not sufficient to give the whole required war reserve, the balance must be paid for by the Home Department and the Government of India in the Military Department.

The second desideratum can only be procured by completely separating India from the Royal Army Medical Corps and having a big enough Indian Medical Service to run (a) all British units deputed to India, (b) the Indian army and (c) the civil requirements.

There would thus be really only one service, recruited by one examination in England, with possibly a fixed percentage recruited in India by competitive examination among medical graduates. The civil portion would be paid by provinces and the military by the Government of India, but all would be one service. British

units on arrival in India would be handed over to the Indian service and have no more to do with the Royal Army Medical Corps so long as they remain in India whether in depôts or on active service. The Indian army would also be run by the Indian service. If necessary it would be easy to give members of the service temporary military rank when on military duty. The necessity of bestowing such rank can be best judged by those who have had experience of military hospitals of various types both before and during the war.

The whole service would be on a time-scale with suitable civil and local allowances and there would, of course, be selection grades at the top from which holders of administrative posts would be selected. The service would be Imperial but distributed as far as possible more or less permanently among the provinces as at present with the Indian Medical Service. There would, however, have to be more frequent redistributions in order to provide for men taking turns at military work which will always be less popular than civil work. The Government of India would also have to retain the appointments to the important civil hospitals and medical colleges and schools.

The discussion of any proposals as to altering the subordinate services should obviously follow the decision as to the imperial service.

A question about the Stores Departments has been brought in. The Inspector-General of Civil Hospitals has not said anything about this. I take it, all civil medical stores should be indented for provincially by the Inspector-General of Civil Hospitals and there must remain a central store department for the military requirements as these cannot be fixed for any province, e.g., a large number of units may be suddenly transferred from one province to another. If possible, however, it would be preferable to abolish the Central Store Department and let the provinces run all the stores. We cannot say how far this would be possible. It would cost no more because there would be less waste.

When the Reforms Scheme comes into force 'Medical' will be most probably a transferred subject, and it is possible that under the auspices of an unofficial minister a more persistent effort will arise to divert funds from European run hospitals and dispensaries to grants to Ayurvedic and Unani institutions and to individuals who control schools under those systems. This will not, however, affect the Indian Civil Medical Service which will at most provide for one superior officer at each district headquarters and some extra men for provincial headquarters, and heads of departments such as jails and sanitation. These will have to remain whatever general lines the development of medicine may follow

Letter No. 1633-M. T., dated the 30th March, 1919, from the Secretary to the Government of Bihar and Orissa, Municipal Department, Medical Branch, to the Secretary, Medical Services Committee.

With reference to the correspondence resting with your letter No. 9—7, dated the 11th March, 1919, I am directed to refer to the note recorded by the Honourable Member in charge of the Medical Department which was forwarded with my letter No. 891-M.T., dated the 26th February, 1919, and to enclose a further note (enclosure No. 1) representing the views of the Local Government regarding the questions on which their opinion was requested in your letter No. 9—4, dated the 23rd February, 1919.

2. I am also to enclose, for the information of the Medical Services Committee, a copy of a letter No. 2692, dated the 19th March, 1919 (enclosure No. 2), and of its enclosures, from the Inspector-General of Civil Hospitals, Bihar and Orissa, and to say that the Lieutenant-Governor in Council is in general agreement with the views expressed by the Inspector-General.

Enclosure No. 1.

Replies to questions for representatives of Local Governments.

1. (a) How would Government view the compulsory military training of some portion of their civil assistant and civil sub-assistant surgeons?

From the point of view of the civil administration, the Local Government see no objection to a course of military training for these officers on their entering Government service. Repeated periods of training would, however, dislocate work and the Local Government doubt whether any commensurate advantage would be gained. The suggestion presupposes that in future all civil assistant surgeons, as well as sub-assistant surgeons, will be recruited on an undertaking of liability to military service up to, say, 20 years' service or an age-limit of 45 years. In view of recent experience such an undertaking seems to be necessary even though it may have a deleterious effect on the recruitment of civil assistant surgeons.

1. (b) Would Government be content to continue to give Indian Medical Service military officers all superior appointments, if the Government were permitted to choose outsiders themselves for special appointments when they wish to do so?

The exact intention of this question is not clearly understood. All superior posts are not at present reserved for officers of the Indian Medical Service. In future the majority of such posts would doubtless continue to be held by officers recruited in the United Kingdom for the superior service, but the Local Government consider it necessary to retain at least the existing pro-

portion of the number of superior posts for selected senior civil assistant surgeons.

2. How do Government view the question of the increase of officers in superior appointments in the civil cadre (1) from the Indian Medical Service, (2) from outsiders?

The Local Government are of opinion that the number of superior appointments might well be increased, mainly for the provision of improved facilities for medical education and for the development of a public health service. With more favourable conditions of leave and study leave a larger reserve may also be necessary. Such additional appointments should be filled mainly by imperial service officers.

3. (a) Are Government prepared to make it a condition of appointing an outsider that the officer should belong to the second reserve? Are they prepared to make it compulsory if he is an Indian?

A condition of appointment rendering an officer liable to be called up for military service might in the Local Government's opinion be made universal in the case of all officers, irrespective of their nationality, although, as has been previously stated, such a condition is likely to affect adversely the recruitment of civil assistant surgeons.

3. (b) Does Government consider that military medical officers are *ipso facto* better in the superior appointments than purely civilian doctors?

The Local Government think that military training has an effect of considerable value in the matter of discipline and *esprit de corps*, but that, from the purely professional point of view, a doctor is none the better, and perhaps in some respects the worse, for the time which he has spent on military duty and which might more profitably have been spent in the performance of civil duties of a much more varied character and offering better opportunities for the maintenance of an up-to-date standard of medical proficiency.

4. In view of what has happened during this war, in the admitted failure of Indian practitioners of standing and of senior civil assistant surgeons to come forward to form an army medical reserve, does Government consider that in the future a reserve could be formed from the independent profession on reasonable terms?

The Local Government are decidedly of opinion that an adequate war reserve could not be formed on a purely voluntary basis and that no reserve so constituted could be relied on.

5. Have Government found that the present leave reserve in civil employ is numerically sufficient to ensure that medical officers get all the leave which is due to them under the Civil Service Regulations and also the study-leave?

The Local Government have been unable in the short time at their disposal to obtain statistics which would have provided material for a complete reply to this question. Speaking generally, however, they consider that the reserve of Indian Medical Service officers has never been sufficient to allow them all the leave to which they were entitled and of which they stood in need.

6. What do you think of the idea of giving free treatment to the families of all civil officers in the outlying districts of the province?

7. What do you think of giving free hospital treatment in selected centres to the families of all the officers in the various civil services?

The Local Government consider that it would be impossible to discriminate between one station and another and if such a concession is to be allowed at all it should be made universal. The concession would be most popular in all other services but would obviously involve a substantial increment to the pay of all medical officers.

8. Would you be in favour of appointing two or more travelling consultants and travelling medico-legal experts in the province?

The Local Government consider there would be nothing to be gained by the appointment of travelling consultants or of peripatetic medico-legal experts.

9. In order to meet the requirements of the army medical officer, it is considered necessary that long periods of civil employ, without the connection with the army, should cease, and that all military medical officers in civil employ should return to the army for periodical

periods of service and military training. Would your Government be prepared to allow the Indian Medical Service officers in civil employ (except those in residual or indispensable appointments) to return for one year, at the end of each five years, to the army? Do you consider that such a return to army employment would dislocate civil work to such an extent as to render such a scheme unacceptable?

This question has already been discussed in the note previously forwarded to the Committee and the Local Government adhere to the views there expressed. While they consider that occasional periods of active service would be most useful for officers as enabling them to realize active service conditions and the treatment of cases caused by such conditions, they are of opinion that periods of one year, in every five, spent in a military hospital in time of peace would teach officers nothing but would on the contrary tend to throw them back.

10. How would you arrange in your province to meet the legitimate aspirations of Indian graduates towards a larger share in the superior civil and superior medical educational appointments with the constantly expressed desire of the European officers of the civil service that they and their families might be in a position always to obtain in all parts of the district the services of a European doctor?

The principle raised here has been dealt with in the reply to the first question. The Local Government see no reason to alter the existing practice by which a certain number of superior appointments are given to officers of the provincial service, but they consider that any considerable increase in the number of appointments given to such officers will have an extremely deleterious effect on recruitment to all services which are still regarded as mainly European services.

11. Has there been in your province any falling off in the quantity or in the quality of the civil medical work done since the Indian Medical Service officers were recalled to military duty and their civil duties handed over largely to civil assistant surgeons?

The only specific information which the Local Government have on this point is in respect of the medical administration of the jails, in which a very serious falling off has been noticeable in the quality of the work. As regards the general quality of civil medical work during the war, as compared with the pre-war periods, the Local Government are not in a position to make any definite statement based on concrete instances and would therefore, prefer to offer no opinion.

Enclosure No. 2.

Letter No. 2692, dated the 19th March, 1919, from the Inspector-General of Civil Hospitals, Bihar and Orissa, to the Secretary to the Government of Bihar and Orissa, Municipal (Medical) Department.

With reference to your letter No. 1207-M.T., of the 11th March, 1919, on the subject of the Medical Services Reorganization Committee, in which you say "you will doubtless have gathered what are the essential points for decision" and have asked me to submit, for the consideration of the Local Government, a note explaining what these points are and how they affect the medical services and medical administration in this province, I have the honour to say that in the absence of any definite pronouncement by the Committee as to either the defects in the present organization of the medical services or the measures which it is proposed to take to remedy them, it is a matter of some difficulty to ascertain from the various schemes which have been put forward and which, owing to the mingling of matters relating to administrative detail with those pertaining to the question of organization, are somewhat confused, what are really the essential points for decision. In attempting to indicate what these points are, I have chiefly consulted Scheme "C" and the paper* "Details connected with Scheme C," which seem to be the most complete and definite.

Though the organization of the purely military medical side of the service does not, perhaps, concern the Local Government directly, as the civil medical service will be to a considerable extent recruited from the mili-

tary service, it is obvious that the organization of the military side will affect the civil side.

I do not think that the designation of the Indian military medical service, whether as Indian Medical Corps, or otherwise, nor the personnel of its administration, call for an expression of opinion from the Local Government.

When we come, however, to the question of executive officers the matter is altogether different. It is proposed that these should consist of—

- (1) Indian Medical Service officers.
- (2) Seconded Royal Army Medical Corps officers.
- (3) Permanently transferred Royal Army Medical Corps officers.
- (4) Promoted military assistant surgeons.

The Local Government will, I presume, approve of (1) which merely continues the existing practice and might, I think, also approve of (4), *viz.*, the occasional promotion of specially selected military assistant surgeons with British qualifications and their incorporation as officers in the Indian Medical Corps.

With regard to (2) and (3) relating to Royal Army Medical Corps officers, as it is apparently intended that (2) seconded Royal Army Medical Corps officers will not be eligible for civil employment, no expression of opinion by the Local Government seems to be called for. In the case of (3), permanently transferred Royal Army Medical Corps officers the case is somewhat different. Though I have great doubts as to the advisability of allowing Royal Army Medical Corps officers to transfer permanently to the Indian Medical Corps and so become eligible for civil employment, as I do not see any good reason why these officers should not have tried originally to enter the Indian Medical Corps, instead of coming in by what might be called the back-door of the Royal Army Medical Corps, as permanent transfer would be limited to officers of a service not exceeding ten years, there may, perhaps, after all be no very serious objection. I think that it would be well for the Local Government to express a distinct opinion on the point.

The composition of the rank and file of the Indian Medical Corps, the questions of the administrative head of the military medical service, administrative officers of commands and such cognate matters do not, I think, sufficiently concern the Local Government as to call for an expression of opinion.

Regarding the increase to the number of executive officers of the proposed corps, I think that Government will probably have no objection to the ratio as proposed, *viz.*, four per thousand for British troops and three per thousand for Indian troops. Perhaps it will not be necessary to express a definite opinion. I would, however, like to point out for the information of the Local Government, that this increase in the cadres will mean, I believe, that during times of peace work will have to be found for these officers and I understand that it is intended that this should be done by increasing the number of civil posts. No doubt there is room for this to a considerable extent under civil administrations, by the development of medical colleges and schools calling for a larger number of medical officers as professors and teachers, and also I think to some extent by duplicating the posts of civil surgeons in some districts where the expansion of medical measures has outgrown the capacity of one civil surgeon to deal with them. This is obviously an aspect of the cases which very closely concerns Local Governments.

As regards the recruitment of officers for the Indian Medical Corps (leaving aside those who may be transferred from the Royal Army Medical Corps) I think that Government will agree that recruitment should be by open competitive examination held in the United Kingdom, that the standard of medical education demanded should be at least as good as at present, and that Indians in the possession of indigenous qualifications only should not be eligible.

The proposal to grant scholarships to Indian students to enable them to complete their education in the United Kingdom with the idea of competing for the Indian Medical Corps would, I presume, result in a larger number of Indians gaining admission to the corps and in view of what is said in paragraph 54, a larger number of Indian officers of the corps would have to be provided with civil employment. This would either have to be done by increasing the number of civil posts or by

reducing the number of Europeans in civil employment. The effect on the provincial medical services would have to be considered. I think that it has been the policy of late years to increase the number of civil assistant surgeons promoted to civil surgeoncies, but if a larger number of Indian Medical Corps officers have to be provided for, it is difficult to see how the aspirations of civil assistant surgeons can be adequately met. There will evidently be some antagonism between imperial and provincial needs and I think that the Local Government may wish to express an opinion.

As regards the conditions for transfer to civil employment which, it is proposed, should continue as heretofore, the Local Government might, I think, express approval.

A very important proposal as affecting the Indian Medical Corps has been made, namely, that the practice of promoting lieutenant-colonels from the civil side to be administrative medical officers on the military side should be discontinued, and it is stated that this practice has been one of the most serious causes of inefficiency of Assistant Directors of Medical Services. I must say that this statement came as a surprise to me. I have always understood that officers transferred from civil to military to take up administrative appointments were, with few exceptions, found to be efficient, in fact more so than officers who had spent a long period in military work alone, the reason being, I think, obvious, namely, that in civil employment there is much more opportunity for gaining varied general experience, not only of medical work proper but also of administration. Officers in civil employment have usually to act much more on their own initiative than is the case in military. I cannot think that the details of military medical administration are so complex and difficult that an intelligent officer cannot, very soon, adapt himself to them. A period of six months' training prior to promotion should, I think, be ample.

As specific instances of the class of senior officer to which I refer, I may, I think, without impropriety, mention the names of Lieutenant-Colonels Sunder, Vaughan and Murray now serving in this province.

I may mention that during the course of my examination by the Committee I was given to understand that the Commander-in-Chief and the Adjutant-General were opposed to the promotion of lieutenant-colonels from the civil to the military side. Under the circumstances the Local Government may not be disposed to offer an opinion on what is mainly a military subject.

It has also been proposed that in the interests of military efficiency, Indian Medical Corps officers in civil employment should be reverted to military duty for six months every five years.

I do not think that this is really necessary. Though probably there would be some advantage to the military side of the service there would be no corresponding advantage on the civil side and it seems to me that it would be very inconvenient for civil administrations to surrender their officers so often, but perhaps with the proposed increased cadre of officers the inconvenience would be less than I anticipate. I think that the Local Government might express an opinion on this point.

As regards the proposal for a Promotion Board, Government might like to express an opinion. I am extremely doubtful of the advantage, of such a board which in my opinion would not give better results than selection by the head of the service with a full sense of responsibility. I am unaware of the reasons for proposing to include combatant officers on the board.

An opinion might also be expressed as to the "War reserve" which it is stated would include all officers of the Indian Medical Corps who have not reached the rank of the lieutenant-colonel and who do not occupy indispensable appointments. In my opinion it would be a great mistake to exclude lieutenant-colonels from the reserve. Officers of this rank of from 20 to 25 years' service are often at their best as regards efficiency and I do not see why their services should not be available in the case of a war emergency. The so-called indispensable appointments must be very few and I can see no good reason for excluding them from the reserve.

The formation of the "Special Reserve" which it is proposed to form from the European, Anglo-Indian and Indian medical practitioners and civil assistant surgeons in India is a question which, I think, particularly affects the Local Government. As regards European, Anglo-

Indian and Indian practitioners I am not at all clear as to how their services would be made available. I am rather doubtful if much could be expected from these classes and the only suggestion which I can make that they should undertake some form of liability to serve on the occurrence of an emergency and that they should be given a retaining fee.

As regards civil assistant surgeons, the Local Government might, I think, form an appreciable reserve from this class by insisting, as a condition of appointment, that they should undertake liability to military service up to a certain length of service or age. Perhaps 20 years' service or 45 years of age would be suitable limits. I have never been able to understand why civil assistant surgeons should not be made liable to military duty as is now the case with civil sub-assistant surgeons.

I would also suggest for the consideration of the Local Government that all medical men employed and paid by Local and Municipal bodies, should, as a condition of appointment, be made liable for military duty as is now the case with Government sub-assistant surgeons. If this be not done, the gradual substitution of Local and Municipal fund employes for Government servants in charge of hospitals and dispensaries which has already taken place to a very large extent, will obviously reduce the available war reserve of men of this class and it is impossible to say up to what point this substitution will be carried. It seems to me that there is a very serious risk of the practical extinction of the war reserve of sub-assistant surgeons. I have no belief in the likelihood of maintaining an adequate war reserve by purely voluntary means. I am quite aware that this proposal means an interference with "Local Self-Government," but when local interests clash with imperial necessities, I think that the former must give way.

As regards a "Home Reserve," which I do not think is a practicable proposal, no expression of opinion seems to be called for.

The establishment of an Indian Medical Corps college, which would, apparently, be administered on the military side might be advantageous, but does not seem to concern Local Governments directly and no expression of opinion seems to be called for.

It seems to be intended that the existing organization, administration and conditions of the civil medical service as a whole, with certain exceptions, should continue. I think that an opinion on this proposal, to which I see no objection might be given.

Probably increases in cadres all round, are required for thorough efficiency.

Government may perhaps express an opinion in favour of the proposal that the term of service of the Director-General, Indian Medical Corps, should be four years and that he should be selected from the whole of the officers of the corps.

Government may also wish to express an opinion as to the proposals that Surgeons-General with the Governments of Bengal, Madras and Bombay should be selected from all Indian Medical Corps officers in civil employment, and not only from those in the province concerned and that they should be nominated by the Government of the province and appointed by the Government of India and also that Inspectors-General of Civil Hospitals should be similarly selected and appointed, the nomination being in the hands of the local government. I am doubtful of the expediency of nomination by governments or local governments, seeing that the selection is to be made from the whole service in India and that governments and local governments would

possess no information as to the merits and claims of officers serving in provinces other than their own.

As regards executive medical officers on the civil side whom it is proposed to recruit from—

- (a) Indian Medical Corps.
- (b) Qualified European or Anglo-Indians (the old uncovenanted officers).
- (c) Promoted civil assistant surgeons.
- (d) Promoted military assistant surgeons,

Government might, perhaps, agree with the exception of (b). The old uncovenanted service was, I believe, not a success, and there seems to be no reason for reverting to it.

It has been proposed that all medical officers of the superior grade in civil employment should be placed in one general list and be available for service in civil wherever the Government of India consider it necessary to place them. Such a large list would, I think, involve too much transference of officers from one province to another with consequent increased expense to Government and to the officers themselves. The question of the great difference of languages in the various provinces would be a practical objection and I do not think that the arrangement would be in any way satisfactory from the point of view of provincial civil medical administration. A distinct expression of opinion by Government seems to be necessary.

The proposal that an Advisory Board on the civil side should be nominated by the Government of India to advise as to selection for all the more important appointments on the civil side that are made by that Government, does not, perhaps, call for an expression of opinion by the Local Government. I am not personally in favour of it, but would prefer that the selection should be left in the hands of the Director-General.

The proposal that candidates for civil assistant surgeoncies should be approved by a committee of five is one distinctly affecting Local Governments. I do not think that such a scheme would ensure better selections being made than under the present system. It would certainly be more cumbersome and the division of responsibility, would not tend to efficiency.

Professorships and allied appointments of colleges.

Although there is no medical college in this province, Government might like to express an opinion on the proposal to which, as it would have the effect of enlarging the field of selection, I do not think that there can be any serious objection.

I have given marginal references to the subjects touched upon and I attach a summary* of the evidence of witnesses.

I regret that I do not feel myself to be in a position to give, further than what I have mentioned above, constructive details regarding the organization which I recommend should be adopted. It would, I think, be useless and impracticable for me to do so in the absence of full information as to existing defects and of necessary details as to the present military medical organization.

I trust that it may not be considered out of place if I suggest for the consideration of the Local Government, that, before committing itself to a definite opinion as to the reorganization schemes, it would be well to wait the receipt of the properly formulated scheme which may be expected to be issued by the Medical Services Committee as the result of their deliberations and which, I presume, before being adopted, will be sent to local governments for remark and criticism.

Letter No. 9-E.—19, dated the 14th February, 1919, from the Secretary to the Government of India, Railway Department (Railway Board), to the Secretary, Medical Services Committee.

With reference to your letter No. 31, dated 5th February, 1919, I am directed to explain that for all practical purposes—there are two classes of railways in India, e.g. :—

- (a) State-worked lines.
- (b) Company-worked lines.

Class (a) is managed directly by the Railway Board and comprises three lines only, namely :—

The North Western Railway with headquarters at Lahore.

The Oudh and Rohilkhand Railway with headquarters at Lucknow, and
The Eastern Bengal Railway with headquarters at Calcutta.

As the first two lines connect with important civil and military stations the existing arrangement is that the services of the European or Indian civil surgeons of these stations are utilised by Government as district railway medical officers in charge of the State Railway (Government) employes in addition to

their other duties, the railways paying allowances, on the scale noted in the memorandum attached (enclosure), for the services rendered. In the case of the North Western Railway, the Inspector-General, Civil Hospitals, Punjab, acts also as Consulting Physician to the Agent, North Western Railway; but as this railway system has now become so large and questions of sanitation are gaining in importance and the number of employés at certain centres are more than a civil surgeon can look after, in addition to his ordinary charge, proposals are in contemplation under which the railway will employ certain whole-time medical officers at the larger centres and utilise the services of civil surgeons at other stations. Colonel Way, R.A.M.C., is now employed by the North Western Railway in formulating a scheme to this end.

The third State Railway—the Eastern Bengal Railway—traverses a part of the country where important civil stations are few and far between. While, therefore, the advice of the Inspector-General, Civil Hospitals, Bengal, is at the Agent's disposal, this railway in normal times employs a whole-time Chief Medical Officer (at Calcutta) and a Deputy (or District) Medical Officer (at Saidpur) of its own. At Dacca—which is detached from the main line—the services of the civil surgeon are utilised.

In addition, all three State Railways employ whole-time assistant surgeons, (including, when available, military assistant surgeons as a war reserve) dispensary staff, etc.

As regards class (b) the companies employ their own chief medical officer and other medical staff, and only occasionally make use of the services of civil surgeons (on the terms stated in note 2 to the memorandum attached) and other Government medical officers. They make their appointments in England, through their Home Boards—or locally—through their Agent and it is unlikely that they will experience difficulty in continuing their present arrangements and method of recruitment. Though hitherto the medical officers have been Europeans, in some instances recently Indians with British qualification have been sent out by Home Boards.

2. The replies to the questions asked in your letter under reply are therefore—

(a) that (apart from civil surgeons) State Railways employ at present only two whole-time European medical men, viz.:—

Colonel Way, R.A.M.C., employed temporarily on the North Western Railway.

Dr. Bishop, Chief Medical Officer, Eastern Bengal Railway (temporarily on military duty overseas. Dr. Bose officiating for him),

but that it is likely that one or two more officers of this class will be appointed in the near future, and that (b) until it is found that the extended employment of Indian civil surgeons does not meet the needs of State Railways, the Railway Board are unable to indicate the extent to which it might be necessary for them to increase their staff of whole-time European medical officers.

Enclosure.

Memorandum showing scale of allowance given to civil surgeons for the medical charge of railway staff.

Scale of allowances.

	Rs.	
Up to 25 employés	Nil.	
25 and up to 99	25	An addition of Rs. 50 may be allowed in cases where administrative duties are performed.
100 and up to 399	50	
400 and up to 799	75	
800 and up to 1,599	100	
1,600 and up to 2,999	125	
3,000 and up to 5,999	150	
6,000 and up to 8,999	175	
Above 8,999 employees	200	

Where a civil surgeon is in medical charge of the staff of two or more railways at any one station, the allowance to be assigned to him should be a consolidated allowance, calculated with reference to the whole number of employés of all the lines, and not be made up of two or more allowances calculated with reference to the number of employés of each line separately. The allowance in such a case should be divided between each line *pro rata*.

NOTE 1.—In the above calculation each European and Anglo-Indian employé is to count as 3 Indians, i.e., a station having 25 European employés and 100 Indians would be reckoned as having 75 plus 100=175 employés. Indian employés drawing less than Rs. 15 a month are omitted from the calculation.

NOTE 2.—The above scale applies to the allowances for the charge of State Railway employés. In the case of Assisted Railways, and State Railways leased to and worked by companies, an addition of 20 per cent. may be made to the allowances which would be admissible under the above scale.

Letter No. 1668, dated the 15th March, 1919, from the Secretary, European Association, Calcutta, to the Secretary, Medical Services Committee.

I beg to submit, on behalf of the Council of the European Association, the following statement on the alternative proposals for the reorganisation and unification of the Medical Services in India.

As the Association is in the main a lay body, and as it is impossible, in the very short space of time allowed us, to consult our branches, I am instructed to refrain from dealing with technical and departmental details.

Generally, my Council desires to support scheme B. Before offering some comments on that scheme, paragraph by paragraph, I am to impress on your Committee the absolute necessity of providing European medical personnel for every military station and at every district centre throughout India. Not only does the absence of a European medical practitioner, or in a military centre the operation of medical etiquette whereby the wives of officers are compelled to resort to the Indian medical officers attached to the regiment though a European medical officer may be in the station, constitute a serious hardship to those at present serving the Crown in India and their families, but it is very likely to deter recruiting of British candidates for all the services in the future.

Paragraph 2 of scheme B.—My Council entirely approves of the proposal to increase the proportion of medical officers serving with the Indian army from 1·2 per mille to 3 per mille.

Paragraph 3.—Many more specialists are needed, to deal with the chief epidemic diseases, in addition

to the medical staff required for general medical relief.

Paragraph 6.—Scholarships for Indian medical students. These scholarships should be tenable for at least 3 years, up to the final M. B. examination. There seems to be no good reason why the holders of the scholarships should be earmarked for the Indian Medical Service. If that service is attractive enough, they will naturally seek admission to it; if it is not attractive, earmarking involves a denial of the best opening to scholarship holders.

Paragraph 9.—Officers of the unified service, in addition to other remuneration, should be entitled, at the end of four or five years, to a free passage to and from Europe for themselves and for their families.

Paragraph 16.—My Council generally approves of these proposals for the creation of a reserve. It seems worth considering whether, in addition to, or in substitution for, a retaining fee or bonus, a certain number of new purely civil posts could be created, acceptance of which would imply obligation to undergo periodic training in military medical administration.

Paragraph 18.—Periodic military training may well be demanded, but reversion to military duty is a hardship, which, unless some compensation be given, may deter recruitment of British candidates.

Paragraph 19.—My Council strongly approves of the establishment in India, for the military service here, of a college comparable to the Royal Army

Medical College at Millbank. Civil practitioners should be granted facilities for profiting by the service college and research institutions.

Paragraph 23.—The necessity of provision of European medical relief for European women and children has already been emphasised. It may be added that, all other considerations apart, in many areas in India the knowledge that a British official

was allowing an Indian, however reputable, to attend his women folk for certain maladies or in child-birth would greatly affect his prestige and that of Europeans generally.

So much for scheme B, which my Council substantially supports. Of the other schemes, the one to which my Council would most strongly object is scheme A.

Letter No. 1003—1919, dated the 19th March, 1919, from the Secretary, Bengal Chamber of Commerce, Calcutta, to the Secretary, Medical Services Committee.

In continuation of the correspondence resting with your letter No. 10—31, dated the 4th March, I am now directed to communicate to you the views of the Chamber with regard to the reference made to them.

2. The Medical Services Committee have, it is noted, been appointed to examine, and to report on, the question of the re-organization of the medical services in India, both civil and military, and they are asked to examine the question from the standpoint that it is desirable that there should be a unified medical service for India. The Committee of the Chamber agree, as a matter of general principle, that a unified service is desirable, and they have read with close attention the different schemes, with this end in view, which are contained in the papers you forward. Most of the points raised in these schemes, and in the lists of questions attached, are of a technical nature, and the Committee do not feel that they are qualified to offer any views regarding these. They do not, therefore, propose to go into any detail, or to recommend any particular scheme for adoption in preference to the others; for a decision as to this requires a knowledge of the subject which the Committee do not possess.

3. The Committee desire, however, to take advantage of the opportunity which has been given to them by stating two general principles which should, in their opinion, be kept prominently in view in any scheme of re-construction of the medical services in India. In the first place it is undeniable that more medical assistance is necessary. Hospital accommodation in

all the larger towns is insufficient, and more medical officers are urgently required in civil employ; but, apart from purely medical needs, the whole country calls for more attention to its health requirements and work can be found in every district for medical officers in connection with sanitation, epidemics of cholera, plague, influenza, small-pox, malaria, hook-worm disease, etc. Whatever basis may ultimately be adopted for the re-organisation of the services, it should ensure the maintenance of efficiency and provide for the increase of personnel.

4. Secondly, the Committee wish to emphasise that the European community throughout India would most strongly resent the introduction of any scheme of reform or unification of the services which might tend to diminish the number of European medical officers available for attendance on Europeans. This point of view is of particular importance when considering the question of European women in this country, who have a right to expect that they may be able to obtain medical assistance from doctors of their own race; while generally, it should be borne in mind that Europeans are hardly likely to come out to India in the first instance if they have any cause to think that in the event of illness they may not be able to obtain European medical aid. For these reasons the Committee are of opinion that the scheme of re-organization should recognise, as a basic principle, that at every military station, and at every civil district headquarters, there should be available a European medical officer.

Letter No. 115 of 1919, dated the 28th February, 1919, from the Honorary Secretary, Bengal National Chamber of Commerce, to the Secretary, Medical Services Committee.

I beg to acknowledge the receipt of your letter No. 10—2, dated the 18th February, 1919, with its enclosures, informing us that a Committee have been formed in connection with the medical services and that they are desirous of obtaining the views of the Bengal National Chamber of Commerce on the problems under their consideration, for which the Chamber is requested to nominate one of their members to give evidence before the Committee.

The Committee of the Chamber recognise the necessity of a unified medical service for India so that the services of the members employed in civil medical service might be readily available for military medical

service when circumstances would so require and also the services of the members of the military medical service might, in ordinary times, be utilised in civil medical works. But as the members of the Chamber are not conversant with the detailed working of the two medical services they would not be able to render any material assistance to the Committee in formulating a scheme for the unification of the two medical services. Under the circumstance the Committee of the Chamber hope that your Committee would excuse them if they do not propose to send up a representative to give evidence before them.

Letter No. 310—85-M., dated the 14th March, 1919, from the Secretary, Chamber of Commerce, Bombay, to the Secretary, Medical Services Committee.

I am directed to acknowledge receipt of your letter No. 12/29, dated 7th instant and its accompaniments in connection with the reorganization of the medical services in India, in which this Chamber was requested to nominate a representative to give evidence on Tuesday the 18th instant.

2. In reply I am to state that owing to the technical nature of this subject my Committee regret they have no useful evidence to place before your Com-

mittee and they do not therefore propose to nominate a representative to appear on their behalf.

3. My Committee, however, would like to emphasise the importance of providing an adequate supply of European medical officers for up-country stations, and in this connection they strongly support paragraph 23 of scheme B in the papers which accompanied your letter under reply.

Letter, dated the 18th March, 1919, from the Secretary, Indian Merchants' Chamber and Bureau, Bombay, to the Secretary, Medical Services Committee.

With reference to your letter of the 18th February, 1919, No. 12—7, I am directed to send hereby views of the Committee of this Chamber on the questions given therein.

Questions for witnesses. (Volume III, page .)

1. My Committee cannot approve of any of the schemes enclosed with your letter as they do not believe that any case is made out for the formation of a unified military medical service for India. In any scheme of re-organization regard should be had to the future constitutional development of India. All medical officers employed on civil work who are being paid from the provincial revenue should be entirely subject to provincial authorities. The Indian Medical Service should be retained in its present form, and, if an addition is to be made to it in order to raise the proportion of Indian Medical Service officers serving with the Indian Army from the present percentage of 1·2 per mille to 3 per mille of its strength, Royal Army Medical Corps officers may be grafted unto it. The required increased number will also be easily obtainable if, as my Committee strongly and emphatically suggest, the proportion of Indians in the Indian Medical Service is increased to 50 per cent. of the total strength. Indian members of the Indian Medical Service have shown during the war their high capacities, and it is but meet and proper that recognition should be given to services rendered by them by increasing the percentage of Indians in the service. My Committee regret that in none of the schemes enclosed with your letter is there a reference to the important question as to what is going to be the proportion of Indians in the Indian Medical Service. They hope that this attempt at improvement of the Indian Medical Service will not result in any injustice being done to the claims of Indians which will be the case if the proportion of Indians in the Indian Medical Service cadre is fixed as less than 50 per cent. Simultaneous examinations in England and India shall be held for the purposes of recruitment. The service shall have two main divisions (1) Military Medical Service and (2) Civil Medical Service. The standard of educational qualifications for both should be the same as that for the present Indian Medical Service, with this proviso that examinations will be held simultaneously in England and India. For purposes of giving military training to candidates who pass their examination in India, a college should be started just as provisional arrangements were made for giving military training to men who had joined the Indian Medical Service during the period of the war. The division between the Military Medical and Civil Medical Service should be fixed up at the very time of admission examinations, but later on provision should be made to allow members of one branch to be transferred to another if they want to. The civil branch should be considered a reserve for military purposes and all its members must be required to undergo military training for a certain period during the war. It was seen during the last war that the independent medical profession in this country responded nobly to the call of duty giving about 800 temporary officers to the Indian Medical Service. My Committee should like to suggest that the possibility thus experienced of utilising the independent medical profession as a sort of a war reserve should not be lost sight of. Before demobilising all these temporary officers they can be asked if they would like to be in the military reserve on payment of a bonus or honorarium. They have got full military training and experience and will prove undoubtedly to be a splendid reserve. Other independent medical practitioners may also be approached with similar terms and there is no doubt that if a reasonable honorarium of say Rs. 50 per month is given, the total military reserve will come up to a large number. With regard to the subordinate department the Committee think that there should be a perfect equality of treatment between sub-assistant surgeons and assistant military surgeons. The former are in no way inferior to the latter in educational qualifications and have shown a good record of work during the war. There is no reason then why there should be such a distinction between these two classes as is at present observed. While a sub-assistant surgeon starts from

Rs. 60 (on military service) and ends with Rs. 250 per mensem (of which maximum promotion there is, it is said, only one instance), an assistant military surgeon starts with Rs. 100 and can rise to Rs. 850 after 15 years' service into the grade of civil surgeons (i.e., posts listed for the Indian Medical Service). With regard to educational institutions my Committee think that only the best men should be appointed to the professorial staff, and appointments should be made by open competition. Members of the Indian Medical Service, both military and civil sections, and the independent medical profession should be deemed eligible for such a competition. If the colleges are staffed by the best available men there is no reason why our young men should go out to foreign countries to prosecute their studies.

2. The Committee cannot say whether the scheme put forward by them will meet with the approval of the War Office and will meet the needs of the army.

3. The Committee believe that their scheme will attract a good stamp of recruits. As under the present circumstances examinations are held only in England, even some of the best students are not able to compete for the Indian Medical Service. If the examinations, however, are held simultaneously in England and India the service will attract the best available talent in the country.

4. The Committee are not aware of the result of withdrawing European medical officers from charge of troops, civil districts and jails in India.

5. The scheme will meet the needs of the civil administration in India.

6. Yes, it will.

7. The military training which is contemplated under the scheme of my Committee will be, it is thought, sufficient for the service.

9. This is already answered in the answer of the Committee to question No. 1.

12. The private practice of officers of the Indian Medical Service has not declined but has on the contrary greatly increased as owing to the spread of education people have come to appreciate more and more the value of consultations.

Special questions.

1. The Committee are constrained to say that the demands of European members of the public services for European medical attendance on themselves and their families are based on purely racial distinctions. As far as my Committee are informed, several Indian medical practitioners have a large practice in the United Kingdom and English ladies have no objection to being treated by them. Nor is this objection to be observed in the mofussil and even suburbs, and in certain cases even in presidency towns, thus showing that the objection is brought forward the most where European medical attendance is available. An attempt is made to draw an analogy between Indian ladies and European ladies in this respect but the analogy is misleading. Indian ladies object to being examined by all male medical practitioners whether European or Indian. Some of them however, who have no objection in this respect, have no objection to being examined by Europeans. On the contrary it appears from the question that some European ladies have objections to treatment by Indians because they are Indians.

2. As said above Europeans have to be satisfied with medical treatment from Indians in absence of European medical practitioners.

Medical Stores Department.

1. Indents are placed with foreign manufacturers or their local agents.

2. There would be no objection to an arrangement which should ensure an equal standard in quality, and reduction in cost owing to purchase in the market in bulk, to increased manufacture in India and to economy in freight and incidental charges. The Committee thinks that the result of almost a total neglect of chemical and pharmaceutical industries is that India has to remain dependent on foreign markets for her supplies of medi-

cines and pharmaceutical products though she is one of the largest store houses for drugs in their raw form in the world. It is hoped that Government will stimulate this industry in this country as it will remove the latter from its present helpless position in such a vital matter as the supply of drugs and medicines. If under the exigencies of any future war, which, the Committee

hope, will never take place, India should be cut off from the rest of the world, her position will be extremely crucial unless she has fully developed chemical industries. In fact during the recent war there were times when several important and essential drugs were not at all available or, if available, were sold at exorbitant rates.

Letter, dated the 20th March, 1919, from the Secretary, Indian Association, Calcutta, to the Secretary, Medical Services Committee.

The Committee of the Indian Association has carefully perused the four schemes forwarded with your letter No. 33—7, dated the 26th February, 1919, but received on the 10th March. I am directed by my Committee to say that it regrets that it cannot support any one of them, except perhaps scheme D, which, however, should, in its opinion, be greatly modified before it can be made acceptable.

2. My Committee is distinctly of opinion that the Royal Army Medical Corps should under no circumstances be unified with the Indian Medical Service, neither should any percentage of that Corps be drafted or seconded into the latter. As the conditions of service of the former, particularly as regards their period of stay in this country, are entirely different from those of the latter, that Corps should be kept entirely distinct and separate from the Indian Medical Service. As Scheme A proposes unification of the two services, my Committee is opposed to its adoption; this scheme further proposes an Indian auxiliary corps, to which the present Indian and Anglo-Indian members of the Indian Medical Service are to be transferred; but the exact position of this auxiliary corps is not defined. My Committee strongly protests against the scheme as it would tend to perpetuate racial distinctions which it is the avowed policy of the British Government to abolish from all branches of the public services.

Schemes B, C and D apparently suggest that graduates in medicine of Indian universities shall not, as such, be eligible for admission to the unified medical service. (*Vide* para. 6, scheme B, para. 18, scheme C, and page 1, scheme D.). My Committee protests against the view that "medical degrees and qualifications gained in India, do not, in all cases, represent the result of a complete medical education." The schemes admit that the independent medical profession in the country supplied something like 800 medical graduates, mostly of Indian universities, for temporary commissions during the war and no allegation has ever been made that any one of these 800 men has been found incompetent in the discharge of his duties, in spite of the fact that he never had any preliminary military training. My Committee goes farther and asserts that the qualifications of the medical graduates of Indian universities are in no way inferior to British registrable qualifications.

3. My Committee being opposed to all the schemes on the grounds mentioned above, begs to suggest—

- (a) that the Indian Medical Service and the higher civil medical service should be distinct and separate bodies;
- (b) that they should be recruited by simultaneous and open competitive examinations held in England and India in the proportion of half and half for the Indian Medical Service and half and three quarters for civil medical service;
- (c) that graduates in medicine of Indian universities should be eligible for admission to these examinations without farther qualifications;

- (d) that the successful candidates should be all graded in military rank and shall be liable for military duties in or outside India, but those entering the civil side, should be only so liable on the break out of war;
- (e) that the successful candidates should undergo a course of military training for one year in Great Britain or India;
- (f) that for this purpose a military medical college should be opened in India;
- (g) that those entering the civil side of the service should undergo courses of medical training at stated intervals with a view to their eventual use on the military side on the break out of war, and that they should be granted such leave for farther study from time to time as may be found necessary;
- (h) that those entering the higher civil medical service should be eligible for appointment as sub-divisional or district surgeons or be attached to presidency or general hospitals or to jails or the sanitary department;
- (i) that members of the independent medical profession of proved merit and ability should be given honorary appointments in the presidency and large district hospitals as has been done in the case of Mayo and some other hospitals in Calcutta; and,
- (j) that a subordinate medical service should be created which should be recruited entirely from Indians and Anglo-Indians possessing any registrable qualification in India and approved officers of the service may be promoted to the superior service by selection.

4. My Committee is confident that the scheme outlined above will attract recruits of the best stamp and meet the demands of professional opinion in England and in India.

My Committee thinks that the scheme outlined above will also meet the needs of the civil administration in India. If war on a large scale breaks out, all officers in civil employ being liable for military duty, would be drafted at once to the military side and their place may be taken by members of the independent medical profession or by open recruitment as suggested above, and my Committee is of opinion that there will never be any dearth of competent men to enter the service, as has been conclusively proved during the last war.

5. My Committee suggests that for supplying the needs of the medical colleges and schools in India and for medical research, persons possessing the highest obtainable qualification anywhere, should be recruited on the advice of a Board created for the purpose and on the advice of experts in England, if necessary. Special pay and allowances should be given to such persons as are recruited for this purpose.

Finally my Committee thinks that the time has come when Indian women may be recruited as nurses for presidency and other large hospitals and provision should be made for such recruitment.

Memorandum, dated the 21st March, 1919, by the Delhi Medical Association.

The Delhi Medical Association has carefully studied all the four schemes forwarded for opinion. We regret very much to say that no one scheme could be accepted in its entirety, for its acceptance would mean a definite set-back to the civil side of the medical service and independent medical profession. Out of all the four schemes, the association agrees partly with scheme 'C' as it is the only one which attempts to create a separate civil medical service, the institu-

tion of which we consider indispensable. We do not approve of the schemes for the following reasons:—

(1) They all attempt at the unification of the two higher military medical services, the Royal Army Medical Corps and the Indian Medical Service, in their own interests only, and to settle some differences that may have arisen between them.

(2) The interest of the very large civil population has been sacrificed at the altar of military efficiency.

(3) None of the schemes take into cognizance the interests of the civil medical service which has been permitted to exist on sufferance as a reserve for the military medical service. It also ignores the claims of the independent medical profession.

(4) All of them unfortunately accentuate the racial distinction which the farsightedness of the Reform Scheme has attempted to banish (*vide* para. 315 Montagu-Chelmsford Reform Scheme).

(5) They all discourage the admission of Indians into the higher medical services through the open door of competitive examination, and put a brand of inferiority on Indian medical education; both of which are retrograde steps.

In order to enable the committee to follow the criticisms better, the salient objections to each scheme are given below.

Scheme A.

It attempts to unify the Indian Medical Service with the Royal Army Medical Corps. This refers only to European officers; Indian officers of the Indian Medical Service cannot be transferred to the Royal Army Medical Corps at all. It combines the advantages of Royal Army Medical Corps with those of Indian Medical Service. The Royal Army Medical Corps will get much higher pay when they are in India than what they get when they are in the colonies. The whole scheme rests on the racial question. Nothing is said about the condition of service in the auxiliary medical corps. There are no improved prospects for the Indians.

Civil medical service to be a war reserve, but with what privileges? Ninety per cent. of the civil medical service to be filled by open competition in the United Kingdom; this does not give increased facilities to the Indians.

The Montagu-Chelmsford scheme, about simultaneous recruitment in India, is ignored.

Scheme B.

Scheme B attempts to unify the Royal Army Medical Corps with the Indian Medical Service. It wants to have more military officers in civil employ. The number of Indian Medical Service in the civil employ is to be increased, not on account of civil requirements, but on account of the increased cadre of the Indian Medical Service. Work will be found for the Service, and not service for the work.

In this scheme, European military assistant surgeon, with a European qualification, can join as officers, but a civil assistant surgeon with the same qualification, cannot. The racial distinction is made so apparent.

The Montagu-Chelmsford Scheme, about simultaneous recruitment in India, is ignored.

The contention that qualifications gained in India do not in all cases represent the result of a complete medical education is not tenable by the fact that they are recognized by the British Medical Council, and by the easy success of the Indian medical graduates in the British universities. If it refers to deficient practical training in obstetrics and gynaecology it may be pointed out that the public as a rule do not avail themselves of the services of male doctors in India as far as these subjects are concerned, lady-doctors being always preferred for the work. If in reply to the argument of Indian students passing British examinations easily, it is alleged that the examinations themselves are not easy, but the teaching is much better, this shows defects in the Indian teaching, for which the Indian Medical Service themselves are responsible and the sooner the teaching here is raised to that higher standard, the better. On the other hand, junior military medical officers fresh from England, with British qualification, in spite of woeful deficiency in those branches of medicine and surgery specially required in India, are given independent charge of station and civil district hospitals.

The word 'indispensable' in para. 13 regarding "residuary appointments" in civil employ is vague, and ill-defined. There have been instances of abuse in the present war, giving cause for grievance to the civil medical officers commandeered for military duty. It is apprehended that when under a certain scheme

the independent and the civil sides of the profession become liable to military duty, the abuse is likely to increase. If indispensability refers to particular individuals, it is ridiculous on the face of it, as absence on long leave, promotion, sick-leave, etc., are easily provided for; but if it refers to a particular service, we strongly protest against such partiality as being against the spirit of declaration made in the Montagu-Chelmsford Scheme.

In para. 16, the scheme does not want to have a separate Indian civil medical service. The military reserve theory has been exploded during this war. Eight hundred civil medical practitioners, official and non-official, were recruited easily on the voluntary system, who have proved competent in every way. We do not object to military training in civil medical service, but their rank and pay should be the same as that of the British commissioned medical officers. Physical unfitness for military duty should not be a disqualification for civil employment. The above facts give greater force to Mr. Chaubal's notes of dissent.

We have no objection to the principle of advisory boards, provided that half the number are Indians. There should be three advisory boards: (1) for professorial and scientific appointments, (2) to deal with the questions of promotion to the administrative grades, (3) for sanitary appointments. Past experience in the medical colleges have proved that the professors do not evince the same interest in the institutions where they teach, or in their pupils, as they do in the service to which they belong. We therefore propose to have a separate cadre of teachers for the colleges, recruited from India and abroad, and not from any particular service, efficiency being the chief qualification for these appointments.

Para. 22, regarding more Europeans in the civil employ. How does it open up finer service to the Indians? Where do the independent medical practitioners come in this scheme except as a passing reference? The Indians do not want any preferential treatment, not asking "everything any more than the European;" they want fair field and no favour.

Para. 23. It is repeatedly urged that European women and children should have a separate European doctor. It is needless to point out that this statement is not sufficiently substantiated by facts. There are many instances, specially in large towns, with both European and Indian doctors, where European women and children willingly avail themselves of the services of an Indian doctor. There are also some instances of Indian doctors practising successfully in Great Britain. Besides, on further grounds it is not necessary to appoint European doctors for European women and children, as the latter spend more than half the year on the hills. Then again, if it be very necessary, they can easily get a European doctor from a neighbouring military station, or railway headquarters, or a neighbouring mission hospital.

To our mind, this plea is not based on any racial question, but on personal convenience, and pleasure of European doctors. They do not care to go to out-of-the-way districts, where the authorities willingly post an Indian doctor, in spite of the fact that he has to attend on Europeans. Much is made of this excuse, and though it has been sufficiently refuted, we fail to see why it is persistently re-iterated. It does not need much stretch of sense to see that this excuse is based entirely on personal interest and convenience. The scheme after all suggests one European medical officer in a unit area—the district. Considering that there will in every case be a large number of European doctors in the military and in the civil, it appears quite easy to arrange their postings at a suitable distance from each other.

The objection that "the absence of suitable European medical attendance in the army and in the civil districts will have a very deleterious effect upon the recruitment in all the European services in India" is untenable. There are instances where even in normal times, permanent European colonies are attended to by Indian medical officers. These are generally out-of-the-way places where perhaps European medical officers do not care to go.

With reference to the last two lines of the concluding para. of this scheme, regarding the fall in the

purchasing power of the rupee, *plus* the rise in value of all the commodities in India, we hope the same principle be applied to the Indians. It is wrong to say that additional work is thrown on the Indian Medical Service. On the other hand, the so-called additional work is usurped by them because such additional work always carries extra allowances, and these officers do not observe the principle of division of labour with their assistants.

Scheme C.

We agree to the suggestion in the scheme that the military and civil medical departments should remain as two separate organisations with two distinct administrative heads.

We object to the exclusive examination in the United Kingdom for recruitment to the Indian Medical Corps, as suggested in para. 17. The bar against the Indian with indigenous qualification is a retrograde step.

We object to the conditions for Royal Army Medical Corps officers joining the new corps as in para. 18. They will only increase the number of Europeans on the civil side.

Para. 27. The position of the military assistant surgeons is very anomalous. There is no equivalent of this service to the Royal Army Medical Corps home service. Why should their existence be considered necessary in India? The Royal Army Medical Corps is a complete service in itself. Why should the whole complement not come out to India when accompanying units of the British army for service in India?

Para. 30. War reserve for the Indian Medical Corps officers. We are not in favour of having military officers in civil employ to form the war reserve. Basing our proposals on the principle of separating the civil and the military service, we object to any military officers being transferred to the civil to form a war reserve. We should suggest the possibility of making the whole of the civil medical service as a war reserve. Of course these officers must receive periodic military training to fit them for military duty. As regards the independent medical practitioners, they should have the opportunity to work in the public hospitals, either as part time paid officers or as honorary officers. In case of mobilization, such independent medical practitioners will be able to release all suitable civil medical officers for military duty. Even some of the independent medical practitioners would be available for military duty, as has been proved during the present war.

Para. 43. (i) Head of the civil medical service should be from the civil side.

(ii) All provincial heads should be selected from the civil medical officers of the province.

(iv) (b) Qualified Europeans or Anglo-Indians constituting the old uncovenanted officers should not be recruited for the higher grade by direct nomination. They should enter by the open door of competition.

(iv) (d) Promoted Indian military assistant surgeons are unnecessary, because the civil medical department shall have nothing to do with the military medical services.

Lower grade (b) military sub-assistant surgeons are not necessary for the same reasons.

The idea in para. 46 that all medical officers of the superior grade in the civil medical departments of the local governments should be placed on one general list, is objectionable. Provincial autonomy in medical service will be more suitable in this respect.

Para. 48. Study periods for civil assistant surgeons should be at least two years.

Para. 51. On principle, military assistant surgeons should not be employed on civil sides. They should be confined exclusively to the military.

Scheme D.

We object to (1) unification of military and civil, (2) examination in the United Kingdom only. If it is meant that the education given in the Indian universities is not to be recognised for admission to the open competitive examination, it would be a retrograde measure, because under present regulations, Indian qualified men can go up direct for the open

Indian Medical Service examination. If, however, the proposal means that in addition to men going up for the open competitive examination privately, a certain number of suitable Indian qualified men will be awarded scholarships to proceed to the United Kingdom as an encouragement, then there can be no objection.

The scheme proposed by the Association.

As none of the four schemes have kept in mind the views expressed by the Public Services Commission, or the principles enunciated in the Indian Constitutional Reform, by Lord Chelmsford and Mr. Montagu, we beg to submit a scheme of our own, and in doing so, we take our stand on the following passages taken from the Montagu-Chelmsford Report.

REMOVAL OF SOCIAL DISTINCTIONS.

315. Subject to these governing conditions we will now put forward certain principles on which we suggest that the action to be taken should be based. First, we would remove from the regulations the few remaining distinctions that are based on race, and would make appointments to all branches of the public service without racial distinctions.

INSTITUTION OF RECRUITMENT IN INDIA.

316. Next, we consider that for all the public services, for which there is recruitment in England open to Europeans and Indians alike, there must be a system of appointment in India. It is obvious that we cannot rely on the present method of recruitment in England to supply a sufficiency of Indian candidates. That system must be supplemented in some way or other and we propose to supplement it by fixing a definite percentage of recruitment to be made in India. This seems to us to be the only practical method of obtaining the increased Indian element in the services which we desire.

PERCENTAGE OF APPOINTMENTS TO BE MADE IN INDIA.

317. We have not been able to examine the question of the percentage of recruitment to be made in India for any service other than the Indian Civil Service. The Commission recommended that 25 per cent. of the superior posts of that service should be recruited for in India. We consider that changed conditions warrant some increase in that proportion, and we suggest that 33 per cent. of the superior posts should be recruited for in India, and that this percentage should be increased by 12 per cent. annually until the periodic commission is appointed which will re-examine the whole subject. We prefer this proposal to the possible alternative of fixing a somewhat higher percentage at once and of making no increase to it until the periodic commission which we propose has reported.

IMPROVEMENT IN THE CONDITIONS OF THE EUROPEAN SERVICES.

318. We recognise and we regret that the improvement of the conditions of the European services in India has encountered opposition from Indians. We hope and believe that if proposals for such improvements are accompanied by increased opportunities being given to Indians in the services this opposition will cease.

WORK AWAITING THE ENGLISH OFFICIAL.

324. We are no longer seeking to govern a subject race by means of the services; we are seeking to make the Indian people self-governing.

In submitting this scheme, we have constantly kept before our mind's eye the principles enunciated in the above passages and have tried our best not to create any artificial bar against any particular service or community. We wish the distinguished authors of these four schemes had shown more breadth of view and less of partiality to their own services. Our scheme offers equal opportunities to all, and favours none. We solemnly trust that the Medical Services Committee, in submitting its report to the Government of India, will keep the principles of justice and equity in mind; and shall not perpetuate or even accentuate the differences already existing in the medical services in the country. The association wants to emphasize at the outset that the civil medical service of the country ought to be entirely separate from the military medical service. We fully appreciate the services rendered to the country and the profession by the Indian Medical Service and their predecessors in the East India Company's service, and acknowledge, with deep gratitude, the splendid pioneer work they have done in creating an independent medical profession in India. While acknowledging that, the Association feels that the time has arrived when they should discontinue any further connection with the civil medical affairs of this country. We shall with pleasure continue to look upon it as our guide, philosopher, and friend, but we feel bound to consider that with the severance of the military medical service from the civil medical service is bound up the growth and development of a healthy and vigorous medical profession which is very necessary in the best interests of the large civil population of India.

One chief argument, which is frequently trotted out, in support of the Indian Medical Service being thrust on the civil side, is that they act as war reserve.

Events during the present Great War, sufficiently demonstrated on what flimsy basis that argument rested. The Indian Medical Service war reserve miserably broke down, and the Government had to fall back upon the junior officers of the civil medical service, and the independent medical profession. Indeed, the number of these temporary officers almost doubled that of the permanent ones. Their work, in whatsoever capacity they acted, has been so far well spoken of. This spontaneous response made to the call of duty by the junior officers of the civil medical service and the independent medical profession in the present war, sufficiently prove that there is no need to keep the permanent Indian Medical Service war reserve on the civil side. We feel certain that if some military training is given to these junior officers, and some willing members of the independent medical profession, as well as retaining fees or bonuses offered to them, there will be no lack of recruitment of medical officers for military service, and members of the medical profession will acquit themselves as honourably in future as they did in the present war. With these preliminary remarks we beg to give a short resumé of the scheme as under.

I. MILITARY MEDICAL SERVICE.

Designation.—This service to be called the Indian Army Medical Service.

(A) *Higher service.—Recruitment.*—The members for this service to be recruited by open competitive examination held simultaneously in England and India. Candidates having qualifications registrable either in the United Kingdom or in India will be eligible for the competition. Candidates getting through in India shall undergo a further course of training (professional and military) in England for at least one year before commencing their duties; and those getting in England, shall do the same in India for a period of one year to get acquainted with the language habits and customs of the people, and to learn military medical subjects at the Army Medical College to be established in India. Those Royal Army Medical Corps who are for the time being serving in India will be seconded to the Indian Army Medical Service.

(B) *Subordinate service.*—This to be recruited in India from candidates with qualifications registrable in India, and to have the rank of warrant officers.

Our Association heartily supports the proposal made in scheme 'C' for the establishment of a military medical college in India.

CIVIL MEDICAL SERVICE.

(A) *Higher service.*—This will consist of:—

1. Deputy-surgeons with a pay of Rs. 400 rising to Rs. 700 by an annual increment of Rs. 50.

II. District surgeons from Rs. 700 to Rs. 1,200 with an annual increment of Rs. 50. European members to have a separation allowance of one-fourth of their pay. Members for this service also to be recruited by open competitive examination held simultaneously in England and India. Candidates having qualifications registrable either in the United Kingdom or in India will be eligible for competition. In the first six years of their services these officers will serve as deputy-surgeons holding charge of subdivisions or be attached to presidency hospitals as junior staff, and perform the duties now assigned to assistant-surgeons. After six years' service, these officers should go abroad on study leave for one year, during which period, they should work at some recognised hospital in the United Kingdom or elsewhere. After the completion of further study, and having proved that they have sufficiently profited by an approved course of post-graduate studies, they will be considered eligible for holding charge as district surgeons. After a period of six years' service, these district surgeons may again avail themselves of a year's study leave to make themselves eligible for administrative or professorial appointments.

(B) *Subordinate service.*—Members of this service shall be called assistant surgeons. They shall be recruited in India from candidates possessing qualifications registrable in India. Admission to the service should be by open competitive examination in the vari-

ous provinces of India. They should have a salary of Rs. 100 rising to Rs. 300 with an annual increment of Rs. 20. Officers of the senior grades of subordinate service who possess qualifications registrable in Great Britain, or who have rendered special service, may be promoted to the superior service by selection. To enable the officers of the civil department to form an efficient war reserve, they should have periodical military training in some military medical college established in India for that purpose. Or they may be deputed to undergo a training of not less than six months at a station hospital, or some other form of military training with troops.

Appointments pertaining to jail and sanitation should be held by officers of the civil medical service.

The administrative appointment to be filled exclusively by officers of the civil medical service by promotion. Their pay and status to be the same as that of officers of similar standing in the other services.

DEPARTMENT OF MEDICAL EDUCATION AND RESEARCH.

This should belong to the civil medical service, but should be entirely distinct from the other branches. Our Association heartily endorses the proposal made in para. 17 of Scheme 'B' with regard to the formation of an Advisory Board to help recruitment to these appointments, but would like to add that this Advisory Board should consist of fifty per cent. of Indians of proved merit and ability, in the profession. This Advisory Board, when necessary, may be helped by the advice of experts in Great Britain.

These posts are on no account to be restricted to any particular service or section of the profession. They should be thrown open to Indians and Europeans alike, efficiency and experience being the only standard of appointments. The Association feels constrained to say that at present the only standard of appointment is the badge of the Indian Medical Service. We fail to see how getting through the Indian Medical Service examination benefits a man for teaching appointment, or for the conduct of a research department. But if we find a suitable man for the post in the Service, we shall very willingly have him. We frankly want to give equal opportunities to all service and non-service men, Indians or Europeans, if they prove their fitness for it. The pay of these posts must be lucrative enough to attract the best men of the profession, men who would devote all their time to educational and research work, without having recourse to private practice. In our opinion a scale of pay from Rs. 1,000 rising up to Rs. 2,000 or so, would be sufficient. Needless to say that these posts should be pensionable. Like other officers of the civil medical service, they also should have study leave to enable them to obtain higher qualifications and improve their knowledge.

THE INDEPENDENT MEDICAL PROFESSION.

In conclusion, our Association regrets very much to say that the services of independent medical profession so far have not been properly utilised. We do think that by obtaining the co-operation of these medical men, the State will benefit pecuniarily, and at the same time it will encourage the growth of an independent medical profession of a very high standard. We consider the existence of such an independent medical profession as an asset to the State which the latter can easily avail itself of in times of emergency and necessity. The present war has sufficiently demonstrated the usefulness of this body. We beg to draw the attention of the authorities with all the earnestness at our command to afford facilities to distinguished members of the independent medical profession, by way of throwing open honorary appointments in the large district hospitals, and the presidency hospitals. Such a step would lighten the work of the present over-worked civil surgeons and would create an independent medical profession worth the name. We fear that our remarks have been too long, but we feel that the importance of the task demanded the close attention which we have tried to give it. If our suggestions are accepted by the Medical Services Committee, we will have the satisfaction of knowing that our labours have not been spent in vain.

Letter No. 4736, dated the 19th March, 1919, from the Principal, Medical College, Madras, to the Secretary, Medical Services Committee.

I have the honour to inform you that, as requested by the Medical Services Committee, a meeting of the Madras Medical College Council was held on the 18th instant to consider :—

“What qualifications military assistant surgeons should have, so that they can receive a proper medical education, and what safeguards should be required so as to retain their services for Government as assistant surgeons.”

The Council decided as follows :—

(1) That the age for entrance to the medical colleges should be raised from 16—20, to 18—22.

(2) (a) That a general educational qualification is absolutely necessary, and should be one which is recognised by the General Medical Council of the United Kingdom, because such qualifications are recognized by Indian universities for the medical courses.

(b) The Council suggests the following examinations :—

(i) Cambridge Senior (*in the required subjects*).

(ii) College of Preceptors' (Medical Preliminary).

(iii) Intermediate in Arts (science groups), Madras University or corresponding examinations of other Indian universities.

(c) That the Government of India be requested to induce the high schools to take up one of the above mentioned examinations instead of the high school examinations.

(3) That the medical course for military pupils should be the same as for university students, namely a five years' course.

(4) That military students should be required to take the university examinations.

(5) That a minimum of 10 years' compulsory service should be required after admission to the Indian Medical Department as assistant surgeons.

In forwarding these recommendations I am requested to explain :

(1) That the Council considers that owing to a definite minimum standard of general education not being required, these boys are induced, by the stipend offered, to appear for the Director-General's entrance examination and to leave school earlier than they would otherwise do, and that, if a minimum standard of general education is insisted upon, the Director-General's entrance examination will only be necessary if the number of candidates is in excess. It should still be the duty of the principals of the medical colleges to eliminate those candidates considered unsuitable for this particular service.

(2) That the high school examination, although probably better than matriculation, is only recognised as equivalent to matriculation, and is a blind alley to many of the students.

(3) That in Madras, if the above scheme is approved, military pupils will generally obtain the L. M. and S., but a few of the more intelligent ones will be able to obtain the M. B., B. S. degrees. Also, that, although the M. B., B. S. degree is a qualification recognized by the General Medical Council, and it is hoped the L. M. and S. will also soon be recognized, 10 years' compulsory service will be sufficient security to Government.

(4) With reference to resolution 2 (b) (iii) the Council did not expect that High Schools would undertake to teach for the Intermediate Arts examination, but considered it preferable to insert it.

Memorandum, dated the 2nd March, 1919, by Lieutenant-Colonel E. D. W. Greig, C.I.E., I.M.S., on the re-organization of the Medical Services in India.

I have read carefully the four schemes submitted and the list of questions. I deal with question* No. 11 as being the one which has special reference to my work in India and on which I am best qualified to speak.

2. In the first place I would point out that, if complete facilities are given for medical research work in India, and if the workers are given adequate status and remunerations, these measures will have a very important influence on recruiting, by attracting highly trained men to enter the service with a view to obtaining a career in scientific medicine.

3. The experience of the war has shown how vitally important medical research work is in maintaining the efficiency of the troops. The construction of proper scales of rations, prevention of diseases, treatment of wounds, etc., have all been worked out for the military authorities by research workers. In the army in India at the present day the machinery for carrying on research work is extremely primitive, almost non-existent. When research workers are reverted from the civil to the military department, the military machinery is quite incapable either of remunerating them properly or of employing them to the full extent of their capacities. This state of affairs calls urgently for improvement.

4. To get the best work done in India I would suggest an organization of medical research on the following lines :—

(1) The creation of an Imperial Health Board with the Director-General, Indian Medical Service, as Chairman, supported by an Advisory Board of the Royal Society in London. The Health Board should have a Standing Committee constantly at headquarters composed of :—The Chairman, a Director of Medical Research, and the Sanitary Commissioner with the Government of India, and the Director, Medical Services in India.

(2) The creation of a central bureau and library. The latter should be complete and up to date and should have an experienced whole-time

librarian. From this bureau the most recent advances in the literature of medicine, etc., would be posted to officers, and research workers would go to the library to study the literature of the subject which they were investigating.

(3) A Central Research Institute, which should be in touch with a hospital, would also be required. An extension of the existing Research Institute at Kasauli would meet this requirement.

5. The Imperial Health Board should direct the research work of both the military and civil medical services in India. The unification of the control of research work in India will remedy to a large extent the defects mentioned in paragraph 4. In some respects the military service has very great advantages for research, e.g., cases can be kept under observation for prolonged periods, more complete records can usually be obtained, etc. In the civil population in India there is a very extensive field for the research worker, perhaps unrivalled by any other country in the world.

6. I consider that the creation of such an organization as has been briefly outlined by me is a matter of great urgency and should be taken in hand with the least possible delay, because it has to be remembered that India is not merely an Indian problem but is also an international one. With the speeding up of transport, India and its various diseases are being brought much closer to other countries than they were a year or two ago. It does not require much foresight to see that an organization for the investigation of disease will be created in India by other countries unless India does so herself. All measures for the prevention and spread of disease must be based on scientific investigation. It is also certain that in these days when man power has been so much depleted no country will stand having disease dumped on it, and the only method of preventing this is by continuous scientific investigation in the country where the disease is occurring.

Memorandum, dated the 12th March, 1919, by Dr. S. N. Tiwary, Officiating Sanitary Commissioner, Bihar and Orissa, on the organization of the Medical Services in India, with special reference to the Sanitary and Bacteriological Departments.

I have no experience of the military medical service, and my experience of the civil side of the medical service is limited to a few years only. I have, however, had good experience of the sanitary department of medical service, having held the appointments of Health Officer, Deputy Sanitary Commissioner and Sanitary Commissioner during the last eleven years. I shall, therefore, confine my criticisms and suggestions to the sanitary service only.

2. The present strength of the sanitary service is inadequate. That it is so, has been admitted in the Government of India Resolution (Sanitary) no. 921—36 issued in May 1912, and the Indian Sanitary Policy issued in 1914. There has not been much development since 1914. In Bihar and Orissa the sanitary service consists of one Sanitary Commissioner, and 3 Deputy Sanitary Commissioners, and the civil surgeon of the district works as the district sanitary officer. A few local bodies also engage health officers who number only four at present. The province has a population of 38,435,293 persons, of whom 34,490,084 are in British territory. It has an area of 111,829 square miles, with 76 towns, 107,949 villages, and 7,442,204 occupied houses. It will be conceded that the area and population are too big for 3 or 4 officers to manage. In England where sanitation is far in advance of this province, for an area of about 58,300 square miles, and a population of about 29 millions, there were, about 25 years ago, 1,300 medical officers of health for rural and urban areas, in addition to an army of sanitary inspectors.

3. It can hardly be said that much has been done in this province to improve sanitation, and prevent disease. Rural sanitation has not been touched, and only a beginning has been made to improve the very elements of sanitation in the urban areas, but even here very little is being done to prevent disease, much of which is preventable. During the last 36 years a period for which statistics are available the mortality in the province has steadily risen, and has practically doubled itself, *vide* appendix which is attached. It cannot all be attributed to better registration of vital occurrences, for I am not aware of any special efforts which have been made to improve it generally. The general experience of the people confirms this, as is occasionally stated in the 'Press', and old folk tell us that they see more disease and death now than they did in their earlier days. It would thus appear that there has been, not only plenty of scope for the activities and energies of the sanitary (department) service, but also a need for them, which the service has not been equal to. I venture to think that this has been due to inadequate manning of the service, its defective organization, and to the want of a vigorous policy against dirt and disease.

4. The belief that 'prevention is better than cure' does not appear to have made much impression so far; more attention is paid to the application of curative than preventive measures against diseases, methods for the prevention of which are now better understood than those for the cure. I maintain that we know sufficient to be able to considerably reduce the incidence of sickness from infectious diseases like cholera, small-pox, plague, malaria, tuberculosis, and hook-worm, the diseases which account for about 75 per cent. of sickness and mortality. I do not agree with those who believe that sanitation and prevention of disease will not make much progress until education has spread more generally among the people. The results of the introduction of vaccination do not support this proposition. On the contrary, my experience is that the uneducated, at the present day, accept vaccination easily, and objections are more often due to want of money demanded by the vaccinator, than to caste prejudice.

I do not believe the prejudices of the people stand very much in the way of sanitary progress, and I think that prejudices will be no bar to sanitary progress, if they are properly handled by the persons who understand them. The cow question is the most touchy question with the Hindus, and most of them know that vaccine is prepared from the calf, yet no serious objection has been raised on this account, for most of them are convinced of its usefulness. In this province, however, the number of high caste Hindus who may take objection to some of the sanitary mea-

asures amounts to about 13 per cent. of the total population. Why should 87 per cent. be deprived of the chance of improving their health for the prejudices of 13? It will be conceded that vaccination has been successful in spite of illiteracy, prejudice, and poverty, and that it is so, because there exists an organised agency (service) to carry out the work in a systematic manner. I maintain that a properly organized and adequate sanitary service is essential for sanitary progress.

5. In the schemes which I have received there are no details of civil sanitary and bacteriological services. Sanitary appointments are referred to in para. 17 of scheme B, and in para. 7 of schemes A and D, and it has been suggested that the civil medical service which should form a war reserve for the military medical service, should hold all civil medical appointments, including those in the Jail, Sanitary, Bacteriological, and Chemical Departments.

6. To limit the recruitment of officers for civil sanitary and bacteriological services to the men who have been primarily selected and trained for medical needs of the military department, is, to my mind, open to very serious objections. Men who have no special qualifications, fitness, aptitude, or liking for sanitary work may be drafted into it. The work of a civil sanitary officer is a hard, uphill task, beset with many difficulties. It is also very unpleasant and trying. The officer is generally exposed to infection. An officer who has been in the general medical department, whether of the Indian Medical Service or its subordinate branches, when taken into the sanitary branch, generally inclines to revert to the medical side, and does not put his mind into the work, for the work on the medical side is more attractive and paying. Men deputed from medical into sanitary service have stayed for the short period of their deputation, or deportation as some call it, and gone. This has, I think, been one of the main causes of the failure of sanitary progress in the country. The right type of man has not been selected, and the work has suffered. I am, therefore, strongly of opinion that the sanitary service should be an entirely separate service from the general medical service, and that the recruitment to the sanitary service should be limited to men who are avowed candidates for sanitary work from the very beginning of their service, and who have special qualifications and training for it. And as men from the Indian Medical Service and its subordinate branches have not shown willingness and liking to sanitary service, the field for recruitment should be made wider, and selection made in the open market. I also think that a man who has been in sanitary service for some years, and has lost touch with the daily progress of medical science, can hardly be of any use to the military or civil medical department. Should, however, the Indian Medical Service be retained as a field for recruitment of officers in the sanitary service, no distinction should be made as regards the pay and conditions of service between the officers recruited from the cadre of that service, and those from outside it. The distinction which exists, at present in the grade of deputy sanitary commissioner, in which the Indian Medical Service officer has a pensionable service, and now gets about 116 per cent. more in salary than his colleague, recruited from outside the cadre of that service, though the qualifications and duties of the two officers are the same, should be abolished.

7. The service should be made pensionable, and the highest appointments should remain open to all the officers of the service. The age limit for entering the service should be increased to 30 years, to enable a man to take an additional qualification in tropical medicine and hygiene, in addition to those of a registrable medical qualification, and a diploma in public health already prescribed. I consider the qualification in tropical medicine and hygiene essential for sanitary work in India.

8. In the higher grade of the service, I think that at least ten men will be required in Bihar and Orissa. One sanitary commissioner, one assistant to help him in office and other routine work, much of which is of technical nature, five deputy sanitary commissioners for the five divisions of the province, and three deputy sanitary commissioners for special research work and investigations.

9. I see no objection to recruitment of men for bacteriological service from the general medical service, but I think it would not be to the best interest of research work to limit recruitment to men of any one service only. The best man should be recruited wherever available.

10. A higher grade of sanitary service is not likely to be of much use without a service of local sanitary officers for each district and town. It is admitted that the civil surgeon, who is the district sanitary officer, has more work than he can do in connection with the hospitals, dispensaries, and jails, etc. He can hardly devote any time to sanitation and prevention of disease, and it has to be admitted that the initiation of sanitary measures in the districts has suffered on this account. I am of opinion that there should be separate sanitary officers in each district.

11. There should be at least one district sanitary or health officer for each district, one assistant health officer for each thana (police station) in the sub-division, to begin with.

12. The district sanitary officer should be required to possess a registrable medical qualification, and should have undergone a recognised course of training in tropical medicine and hygiene, and sanitary engineering. The health officers for towns should also be required to possess similar qualifications. They should be recruited in the open market, and their services should be made pensionable and graded, and remain under the control

of the local government till the whole service has been formed, and the men have become trained and thoroughly accustomed to their work. Some of them should be promoted to the grade of deputy sanitary commissioner after ten years of service.

13. The assistant health officers should possess a medical qualification registrable in India, and should have undergone a course of training in tropical medicine and hygiene, and sanitary engineering. Their services should also be pensionable and under the control of the local government, as are those of the health officers. Some of these officers should be promoted to the lower grade of health officers after 15 years of service.

14. The sanitary inspector should be a sub-overseer, or overseer, trained in sanitary engineering and hygiene, as prescribed for the course of sanitary inspectors, and should eventually replace the present sub-overseer who has no such training.

15. I am inclined to extend the scope of sanitary service, and include in it the existing sanitary engineering and the bacteriological staff, and other sanitary appointments such as those under the Mining Settlement Act, and a few men for entomological work, and place the different branches of the service under one head for co-ordinating their work and energies. The head of the service should be a medical officer of the sanitary service who will be able to follow the workings of its several branches, and apply them practically.

APPENDIX.

Decennial death rates per mille from different disease and total causes for the last 36 years.

Years.	Cholera.	Small-pox.	Plague.	Fevers.	Dysentery and Diarrhoea.	Respiratory diseases.	Injuries.	Other causes.	TOTAL.	REMARKS.
1883—1892	2.41	.24	...	14.41	.9541	3.49	21.91	
1893—1902	2.34	.39	.38	21.15	.85	.003	.49	5.94	31.54	
1903—1912	3.02	.37	1.76	22.09	.95	.16	.52	7.02	35.89	
1913—1918	2.8	.2	1.1	23.3	.8	.2	.5	6.3	35.2	For six years.

Memorandum, dated the 13th March, 1919, by Lieutenant-Colonel F. H. G. Hutchinson, M.B., I.M.S., Sanitary Commissioner, Bombay, on the re-organization of the medical services in India.

Defects in the existing organization.

1. The chief defect is the fact that the existence of two distinct services perpetuates the line of cleavage between Europeans and Indians. The Royal Army Medical Corps deals with European personnel only, while Indian Medical Service officers in military employ are confined mainly to Indians. During the recent war "combined" field units were used. This was a step in the right direction, but peace units for efficiency's sake should in constitution correspond as far as possible with those for war. Medical men in treating disease have to take into consideration individual peculiarities, and it is essential if this function is to be carried out efficiently in war that medical officers in peace time should have every facility for observing individuals of all races found in India. Combined station hospitals for British and Indian troops are, therefore, necessary in peace time. If this be admitted, a union of the medical services is also necessary: otherwise inter-corps jealousies, due mainly to different conditions of service, will be maintained and interfere with the smooth working of the hospitals.

2. A second defect is that officers of the Royal Army Medical Corps and officers of the Indian Medical Service in military employ have little opportunity for a varied medical practice which the wards of military hospitals do not provide. This must interfere very gravely with the professional efficiency of military medical officers. This defect also indicates union, so that as many of the military medical officers as is possible may have opportunity for all branches of medical work. This can be provided in two ways: (a) by adding wards for the civil population to military station hospitals, and (b) by limiting the period of civil medical employment of officers

with a view to giving a larger number the advantages derived from a varied practice. It may be said in parenthesis that the expense of hospital construction is so great that the combination of civil with military wards may prove economical.

3. A third defect lies in the existence of two subordinate services in addition to the two distinct superior services.

4. A fourth defect is found in the exclusion of Indian Medical Service officers from the position of Director, Medical Services in India. The Indian Medical Service is thus branded as an inferior service.

All four schemes aim at removing the lack of harmony due to the existence of two distinct medical services. As I am not in agreement with any, I propose to detail shortly what I consider to be the main defects in each scheme, and I attach the essential parts of a scheme drawn up privately in February 1918, in Poona, by four officers of the Indian Medical Service (two in military and two in civil employ), which will, in my opinion, more fully remove existing defects.

Scheme A must necessarily fall to the ground, for, it suggests the inclusion within the "unified corps" of an "auxiliary" corps composed wholly of Indians and Anglo-Indians for service with Indian troops only. Although it is not definitely so stated no member of this auxiliary corps can hope to rise even to the position of officer commanding a station hospital: for, station hospitals are in the scheme combined for British and Indian troops under one commanding officer. The members of the auxiliary corps are for Indian troops only, so no member of it can be commanding officer of a combined hospital. In this way the scheme creates what is really a third subordinate corps, and instead of

mitigating, exaggerates the existing defects in medical organization. It will also enhance the present discontent among Indian practitioners, in that it will only be possible for them to belong to a subordinate corps. This alone condemns the scheme.

Further the scheme fails to provide a sufficient safeguard for the vested interests of Indian Medical Service officers who have completed 15 years' service, and who will not be permitted to join the new corps, but will be seconded. As a result of the war and the consequent expansion of the Royal Army Medical Corps all the senior officers of that corps have received rapid promotion in comparison with officers of the Indian Medical Service having the same length of service. The senior officers of the existing Indian Medical Service will under the new scheme be permanently barred from administrative rank.

The weakness of the arguments in favour of the scheme is revealed by the "points" brought forward by the author. None of the three points will bear examination if the existing defects in medical organization are admitted.

The remarks already made show that the term "Genuine Unification" cannot be applied.

One Royal Corps to provide the military medical needs of the Empire has an attractive sound; but, India is an Empire in itself, with a population three times as great as the whole of the remainder of the British Empire. The population comprises many races with individual peculiarities and distinct languages. Any scheme for a unified service for India, an essential part of which is the formation of a war reserve composed in part of European members of the corps, should provide that the European members should spend their whole service (apart from leave) in India. The idea that prolonged residence in India is necessarily associated with destruction of health and energy has been exploded long ago. The records of the Finance Department with regard to the prolonged payment of pensions to retired officers will discredit the former; while, if energy be measured by capacity for work—the only form of energy which matters to Government—it will be found that the day's work of the average Indian Medical Service officer does not compare unfavourably either in quality or quantity with that of the average Royal Army Medical Corps officer in India. The tendency "to adopt the line of least resistance" is in military medical matters not confined to India. The Indian Medical Service as a service has never acted on this principle; for, it will be admitted by any impartial observer that its history has been associated at every stage with marked progress in the practice and teaching of medical science in all its branches. Whatever scheme is accepted for the future it must be understood that civil employment is not to be the main inducement for recruiting. Civil practice is an incident in a military medical career, provided with the object of making the officer more efficient as a military medical officer. A general level of efficiency can only be obtained by throwing open civil practice to the officers of the corps. The existence of specialist and professional posts, for which officers of the corps will be eligible, and some of which should be reserved for the officers as specialists are required with the army, will prove an added attraction; but the plain unvarnished bait for the medical student must be an attractive "military medical career"—not an attractive "military career" as specified in the points of scheme "A." A military medical career can only be attractive if it provides facilities for the keen professional man to study and practise his profession.

Schemes B and C are both faulty in my opinion, because they do not allow for the fact that conditions in India have materially altered since the Indian Medical Service came into being. In those days there was no other means by which western medical knowledge could be placed within reach of the civil population. Since then, a fairly large and constantly increasing independent medical profession has come into existence mainly through the teaching ability of certain officers of the Indian Medical Service. The medical practitioner thinks the Indian Medical Service officer occupies too favourable a position as regards private practice owing to his official status.

Scheme B recognises that greater facility should be given to Indians to compete for the entrance examination for the new corps, and suggests certain scholarships

tenable in the United Kingdom by selected graduates of this country. This is right, but there should be a definite relation between the number of these scholarships and the vacancies to be competed for. If, by means of these scholarships, Indians receive State aid to enable them to compete for 50 per cent. of the vacancies, the disadvantage to them of the examination being held in England will be annulled.

In the future military needs of India necessitate an increase in the number of military medical officers in civil employ, as the author of scheme B anticipates, the reasons for this should be clearly stated, otherwise, the dissatisfaction of the independent medical profession will be enhanced.

There are three main reasons for the civil employment of military medical officers :—

- (a) The maintenance of a general level of efficiency among officers of the corps in all branches of professional work.
- (b) The economic employment of military medical officers for whom there is not sufficient work with the army in peace time.
- (c) The necessity for specialists with the army both in peace and war. The Indian Medical Service during the past war provided from its own cadre the specialists necessary for work in the field, and can do so in the future, if the necessary facilities are provided. Apart from these claims the civil medical department should be recruited from the independent medical profession.

It is difficult to criticise scheme B in detail, for it does not make definite recommendations, but suggests points on which the committee should formulate recommendations.

Scheme C suggests two services under separate heads: one military and one civil. The civil is the predominant service, for the head of the civil department will be director-general of the new corps. The two services will be co-ordinated only through the ordinary and special war reserves. A more efficient link would be provided by making the director-general of the new corps the nominal head of both services. Whether it will be necessary to appoint a special officer with the rank of major-general under him to carry on the duties of Director, Medical Services in India, must be left to future consideration. The scheme evidently contemplates further recruitment for the military and civil assistant surgeon classes. The name "assistant surgeon" causes considerable bitterness of feeling. There is now no necessity for retaining this class. The extension of the period of medical study to 5 years places a registrable medical qualification, commission in the new corps and employment in the civil department within their reach. The carrying out of military medical duties now performed by military assistant surgeons can in future be relegated in part to sub-assistant surgeons, who would drop this title and be given the rank of jemadars, etc., and in part by the attachment for temporary duty at the beginning of service of ordinary recruits for civil medical employment.

Another suggestion in the scheme is for a promotion board composed of medical and combatant officers. The inclusion of combatant officers would be a mistake. It is hoped that in future the Minister of Health in the Government of India, or the Member in charge of public health will be advised in public health matters by a Board of which the director-general of the corps would be president. Each member of the Board would represent a separate professional interest, and one of them would be the Director, Medical Services in India. The Board as a whole or sub-committees would make recommendations for appointments and promotions, and those relating to officers in military employ would go to the Commander-in-Chief.

The scheme limits the selection of local governments and administrations to officers permanently in civil employ for appointment to the post of surgeon-general or inspector-general of civil hospitals. This limitation is a corollary to the suggestion that an officer on attaining 20 years' service should decide finally if he wishes to remain permanently in civil or to revert to military duty for good. This would be right if military medical officers in civil employ had not received periodic military training. The objection to employing senior military

medical officers in civil will disappear if the same rules for reversion for periodic training are made applicable to them. This will be to the advantage of local governments and administrations, for they will thereby gain an insight into the administrative capacity of a larger number of senior military medical officers and their field of selection will be increased. Another advantage is that senior officers with the experience gained by working in large hospitals will be available in war for general hospitals.

The scheme definitely excludes Indians with indigenous qualifications only from the new corps. This is not right. What is wanted is an assurance that all candidates at the entrance examination have had a sufficient experience of English medical practice. This can be obtained by Indian graduates by post-graduate study in Europe, and they need not be hampered by the necessity for working for an extra qualification.

The scheme further suggests examination for promotion to the ranks of major and lieutenant-colonel, and for the establishment of an Indian Medical Corps College. An examination for a lieutenant in military subjects is essential before promotion to captain. Examinations in professional subjects are a test neither of knowledge nor of efficiency; unfortunately a competitive entrance examination is necessary: no further examinations should be insisted on. Regular periods spent in study should be compulsory.

The major portion of the teaching which would be carried out by the proposed Medical Corps College will be efficiently performed at one or other of the schools of medical research (tropical schools) to be established in India. A college for training military medical officers in staff duties may possibly be necessary: on this I cannot speak.

The scheme provides for the seconding of Royal Army Medical Corps officers for duty in India. This question is discussed in the scheme I attach. Seconding, after adjustment is completed, should be limited to junior officers who wish for permanent transfer. As regards the war reserve, India can and should provide all the men who will be required. All medical men who obtain employment in the civil medical department should form part of the special reserve—this should be a condition of employment. The question of their initial and subsequent training is also discussed in the attached scheme.

The suggestion for a lower grade of nurses (para. 30) to work in Indian station hospitals does not commend itself to me. A lower grade infers less important duties less intelligently carried out. Apart from nursing, one of the most important functions of the army nurse, is to train orderlies. Are the orderlies in Indian hospitals to have less efficient training?

The institution of two nursing services is as much to be avoided as of two medical services.

In para. 38 the scheme suggests a separate cadre of specialists for service with the army to be recruited from the profession in the United Kingdom. If proper facilities for civil practice be afforded, the corps will contain in its cadre sufficient specialists for ordinary purposes. It is presumed that an Alienist Department will be developed in India; this will serve the needs of both the civil and military populations. In the scheme attached, a public health section for the corps is advocated; this will serve for the performance of routine duties. Specialised research may well be left to the schools of medical research (tropical schools) and institutes for special research. It is probable that some of the experts in specialised research on the staffs of the schools and institutes will be recruited from outside India.

In the paragraph relating to the public health section for the corps (*vide* annexure) mention is made of the close connection between the health of the army and that of the civil population, and a link between the civil and military public health departments is suggested.

In order to make this clearer I would indicate briefly how the future sanitary and bacteriological departments should be constituted.

There is considerable attraction in the suggestion that the two departments should be amalgamated into one public health department. This would undoubtedly be done if a sufficient safeguard could be provided against interchange of duties. My personal opinion is that there should be two departments—a department of public

health and a department of medical research—thus abolishing the existing nomenclature—sanitary and bacteriological.

The public health department would be constituted as follows:—

- (a) District health officers and municipal health officers with their subordinate staffs.
- (b) Chemical analysts and bacteriologists for laboratories in which routine duties would be carried out—such as water and food analysis, examination of morbid specimens and perhaps preparation of bacterial and calf vaccines. It must be remembered that it will be many a long day before local bodies can maintain separate laboratories. Combined laboratories each to serve several local bodies are necessary. This necessity is not confined to India. Professor Matthew Hay of Aberdeen recommended such combined laboratories for Scotland.
- (c) A staff of Inspectors with duties similar to those performed by the medical inspectors under the local government board of England. The work would be mainly epidemiological and inspectorial. The present deputy sanitary commissioners, supplemented as need arises, would carry out these duties.
- (d) Sanitary commissioners under local governments and administrations.
- (e) Sanitary commissioner with the Government of India.

Objection has been taken to the designation 'Sanitary Commissioner.' The first obvious alternative is 'Director of Public Health.' The initials, which coincide with those of the Diploma of Public Health, might cause inconvenience.

The following designations, any of which would be suitable, are suggested:—'Director of Preventive Medicine,' 'Commissioner of Public Health,' 'Inspector-General of Public Health.'

The nucleus of the department of medical research would be formed by the schools of medical research, the institutes for specialised research, Pasteur institutes and so on. For the co-ordination of work a Director of Research is needed, and he and the Sanitary Commissioner with the Government of India would work in close co-operation. Both officers would be on the staff of the director-general of the new corps, and would be on the advisory board referred to previously, of which the director-general would be President, and the Director, Medical Services in India, a member. Thus the link between military and civil public health work would be secured. It is assumed that advisory boards for local governments working in close co-operation with the central board will be established.

Now for recruitment. The district and municipal health officers will be recruited locally. They will be servants of the local bodies, who may possibly receive grants-in-aid from government towards their salaries. Their names should all be maintained on one general roster mainly for convenience of transfer, when the need for that arises and the consent of the local bodies concerned is obtained. The principle of the maintenance of the war reserve should be maintained in recruitment for classes (b) and (c) of the public health department. When this claim is satisfied recruitment should be local. An essential proviso is that the claims of any officer for retention in the department, whether he is an officer of the new corps or recruited locally, are considered at least once in every 5 years.

It is suggested that with a view to cementing the link between the military and civil public health needs, appointments as sanitary commissioner should, as a rule, be reserved for officers of the new corps.

Recruitment for the research department should not be confined to India. Suitable local candidates, whether officers of the new corps or not, would be selected as a rule for ordinary appointments, but for highly specialised appointments the candidature should be open to the whole world, and selection made by the Government of India on the advice of the Central Advisory Board, who would, if necessary, be backed up by the opinion of the Advisory Committee of the Royal Society.

APPENDIX.

SKELETON SCHEME.

1. MILITARY MEDICAL SERVICE FOR INDIA.

Reasons.

(a) The formation of combined station hospitals for the treatment of the sick from European and Indian units.

(b) The actual formation of combined medical units mobilised for field service.

2. A DISTRICT INDIAN MILITARY MEDICAL SERVICE.

Reasons.

(a) The necessary recruitment of Indians for commissioned rank.

(b) Short tours of service in India are, in the case of Europeans, prejudicial to the acquirement of knowledge of the languages, customs and caste peculiarities of Indians, without which there can be no real sympathy between the European and Indian members of the service, and between European medical men and their Indian patients.

3. ORGANIZATION.

(a) Commissioned medical officers—European and Indian.

(b) Nursing sisters.

(c) Quartermasters.

(d) Sub-assistant surgeons, who should rank as jemadars, subadars and subadar-majors.

(e) Clerical and dispensing section.

(f) Nursing section—European and Indian.

(g) Cooking section—European and Indian.

(h) General duty section—Bearers and ward servants. Bhisties. Dhobies. Mehtars.

Military assistant surgeons are designedly omitted: reference to them will be made under the heading "Adjustment."

With the above organization the "Service" becomes a "Corps"—The Indian Medical Corps. The dignity of the corps would be enhanced by the prefix "Royal."

4. RECRUITMENT.

(a) *Commissioned medical officers.*—(1) By a competitive examination to be held at regular intervals in London.

It is suggested that the precedent of the civil services be followed, and that a combined examination be held for candidates for all the medical corps and services of the Empire. Indians to be eligible for the Indian Medical Corps only. With this exception the regulations at present in force for the examination of candidates for admission to the Royal Army Medical Corps should be adopted.

Before appearing for the entrance examination, Indian candidates should undergo a course of training at a recognized hospital in the United Kingdom, with a view to learning something of British ways, manners and customs; also of British methods of sanitation, hospital treatment and dietary, and other features of western medical practice.

To secure a sufficiency of Indian candidates, and to assist those who cannot afford the long residence in the United Kingdom, it is proposed that scholarships, corresponding in number to half the average annual number of vacancies in the Indian Medical Corps be offered for competition in India among selected graduates of the Indian medical schools. Each scholarship should be tenable for 2 years. No scholar should be eligible to compete at the entrance examination for the Indian Medical Corps, without the production of evidence satisfactory to the Secretary of State that he has completed at least one year's study at a recognised medical school

in the United Kingdom: such evidence would ordinarily include a British medical qualification. A scholar should cease to draw his scholarship from the date on which he commences his salaried career as an officer on probation in the Indian Medical Corps, in the event of his not having completed his tenure before that day.

(2) To maintain a close connection between the Military Medical Corps of the Empire it is suggested that an "x" percentage of the officers' cadre of the Indian Medical Corps be reserved for officers of the Royal Army Medical Corps, to be nominated by the D. G., A. M. S., from officers of that corps who volunteer for service in India. A secondary advantage of this suggestion is that a certain proportion of Royal Army Medical Corps officers will gain experience in tropical diseases. Such officers should be below the rank of major on nomination, and should decide before the completion of 5 years' service in India, and in every case before the attainment of the rank of major, whether they elect for permanent service in the Indian Medical Corps, or for reversion to the Royal Army Medical Corps.

It is not possible to appraise "x" now, but it is suggested that it bears some relation to the relative number of British and Indian soldiers in the Indian Army. The total number of Royal Army Medical Corps officers in the Indian Medical Corps, both incorporated and serving temporarily, should at no time exceed this "x" percentage.

(b) *Nursing sisters.*—After absorption of the Q. A. M. N. S. I. in the Indian Medical Corps, recruitment should be on the following principle:—A fixed proportion to be nominated by the D. G., A. M. S., from the Home Army Nursing Service; the remainder to be recruited in India from the staffs of recognized hospitals.

(c) *Sub-assistant surgeons.*—To be recruited as at present, but to rank as jemadars, subadars and subadar-majors. The inclusion of this class of officer in the corps is necessary to provide medical attendance for small outposts and other similar duties.

(d) *Clerical and dispensing section.*—To be especially recruited from Indians literate in English. It is suggested that all clerks be trained in dispensing.

(e) *Nursing section.*—(1) *British.*—To be recruited partly from the Royal Army Medical Corps for a tour of service in India, and partly from British units in India. The Royal Army Medical Corps personnel, on termination of tour of Indian service, to have the option of reverting to the Home Establishment, or of joining the Indian Medical Corps permanently.

(2) *Indian.*—To be recruited according to caste, in numbers sufficient to meet war requirements.

(f) *Cooking section.*—(1) *British.*—Non-commissioned officers and men from the Royal Army Medical Corps cooking section for instruction and supervision.

(2) *Indian.*—(a) *For British troops.*—Mohammedans, Parsis or Native Christians.

(b) *For Indian troops.*—According to caste, as under Nursing section.

(g) *General duty section.*—No special remarks are necessary.

N.B.—All Indians taken into the corps should be enrolled and attested, and should be given all privileges enjoyed by combatants according to rank.

5. WAR RESERVE.

(a) *Officers.*—The war reserve for officers of the Indian Medical Corps should be:—

(1) *Ordinary reserve.*—Officers serving in the Government civil medical departments.

(2) *Special reserve.*—Private practitioners, who volunteer to undertake the performance of military medical duties in times of national emergency.

The civil medical department or ordinary reserve, should be composed of officers seconded from the Indian Medical Corps, and of officers recruited from the graduates of the Indian medical schools.

The number of officers seconded from the Indian Medical Corps would be regulated entirely by military considerations. A roster of applicants for civil medical employment should be kept, and officers seconded according to their position on the roster. Local governments should, however, be able to apply for the services of suitably qualified officers to fill special appointments; such as, Principals of Medical Colleges, professorial

posts, etc. Apart from officers appointed to such posts, it is suggested that the period for which an officer may be seconded should not exceed 4 years. At the termination of this period the seconded officer should return to military duty, but should be permitted to re-enter his name on the civil employment roster.

(b) *Nursing sisters.*—All nurses employed in Government civil hospitals should be placed on the war reserve.

It is suggested that the nursing sisters of the Indian Medical Corps should be eligible to be seconded for positions of importance in connection with large civil hospitals.

(c) *Sub-assistant surgeons and other ranks.*—The whole subordinate medical and dispensing personnel and menial establishment of Government civil hospitals and dispensaries should be considered as part of the war reserve.

6. PROBATION AND TRAINING.

(a) *Officers.*—After passing the entrance examination officers should undergo a course of training in discipline and military medical organization at Aldershot. Instead, however, of going to Millbank it is suggested that officers of the Indian Medical Corps should complete their probationary training at one of the tropical schools in India. This course of training should extend over 6 months. At its close each officer should be required to pass the lower standard vernacular examination in addition to one in technical subjects. Munshis should be provided free by Government, and the reward for this preliminary examination abolished. Within 3 years of appointment every officer should pass the higher standard vernacular test.

Before the completion of 5 years' service an officer, not being an Indian, should be permitted to exchange with an officer of equal status in one of the military medical corps or services of the Empire.

The subsequent training of officers should include periods of study leave; but it should be recognized that periods of study leave at uncertain intervals can never entirely replace regular practice in the wards of a general hospital; and that such general practice must be provided if a general level of professional efficiency is to be secured among the officers of the Indian Medical Corps. To furnish this general hospital practice it is suggested that the combined hospitals for troops should include wards for women and children and for the treatment of the civilian sick among the population of the neighbourhood. When the city is close to the cantonment, the existing civil hospitals may have wards added for the accommodation of soldiers who are seriously ill: the soldiers with mild complaints could be treated in detention wards near the barracks. When a considerable distance separates city from cantonment, it may be necessary to add wards to the station hospital for the sick of the civil population. Whichever course be adopted, the experience gained in the present war with mechanical transport will be invaluable.

In connection with every large cantonment there should be one combined infectious diseases hospital for the military and civil populations.

Further general hospital practice for officers of the Indian Medical Corps could be secured by mobilizing certain sections of field ambulances for permanent use as travelling dispensaries. In ordinary times the officers with these sections would treat the sick in the villages; the more serious cases would be conveyed to the station hospital. In epidemic times such travelling dispensaries would be invaluable, not only to the population of the affected area, but also in protecting cantonments from the entry of infection.

In these ways the officer cadre of the Indian Medical Corps which must obviously be in excess of the peace requirements of purely military units, could while enhancing its value to the State be utilized for the benefit of the civil population without encroaching on the legitimate expectation of practice of the civil medical men.

With a view to keeping the Indian Medical Corps in touch with its sister corps, and acquainted with developments in military medical organization in the United Kingdom, it is suggested that an officer of the Indian Medical Corps, not lower in rank than a lieutenant-colonel, be appointed as "liaison" officer to the War Office in London. The period of appointment should

not exceed two years, and should immediately follow a tour of Indian service, in order that he may be familiar with developments in India.

(b) *Officers of the war reserve.*—Training is suggested only for the officers of the civil medical departments who are not seconded officers of the Indian Medical Corps.

The best time to train these officers is on first appointment. Every officer should be attached to the Indian Medical Corps for the first 6 months of his service. During this period he should be given temporary rank as lieutenant, and be employed as house physician or surgeon of one of the station hospitals. His military training would, therefore, be of value to him in his subsequent civil career. After 4 years' civil employment each officer would be attached for one month for training with a field medical unit during military manoeuvres, or for a similar period to the field ambulance working as a travelling dispensary in the district in which he is serving.

(c) *Sub-assistant surgeons of the war reserve.*—Sub-assistant surgeons on first appointment to the civil medical departments should also be attached to the Indian Medical Corps, for training. They should be called up periodically for training with the field ambulances which are touring in the neighbourhood of the hospitals and dispensaries in which they are serving.

7. ADJUSTMENT.

At the inception of the corps arrangements for guarding vested interests will be necessary:—

(a) The D. G., I. M. C., as the head of the medical organization of India, should rank as lieutenant-general. He will be D. M. S. in India. The question of whether it will be necessary to appoint a major-general, to carry on these duties under him must be left to future consideration. With this exception every officer, whether Indian Medical Service or Army Medical Service then holding an administrative appointment should continue in his appointment till he has completed his term of duty. Subsequent promotion to administrative rank would be made by the D. G., I. M. C., with the reservation that an "x" percentage should be on the nomination of the D. G., A. M. S., until such time as matters are adjusted in the manner indicated below.

(b) All permanent officers of the Indian Medical Service will be enrolled in the corps; and also an "x" percentage of Royal Army Medical Corps officers evenly spaced according to the length of service and nominated by the D. G., A. M. S., in consultation with the D. G., I. M. C. Adjustment is suggested in two directions: (1) promotion to the rank of lieutenant-colonel should be to fill vacancies in the cadre of lieutenant-colonels, and not by length of service: (2) all Indian Medical Service officers, who have lost relative seniority through the rapid promotion of Royal Army Medical Corps officers since the outbreak of war, should have their positions restored by such antedating of their promotions to the ranks of lieutenant-colonel and major as is necessary. This proposal does not involve the grant of back pay.

(c) Any officer, Royal Army Medical Corps, nominated for service with the Indian Medical Corps who is below the rank of lieutenant-colonel, should be allowed to elect for permanent service with the Indian Medical Corps before attaining the rank of lieutenant-colonel or the completion of five years' service, whichever comes first. The right of the D. G., A. M. S., to nominate officers, Royal Army Medical Corps, to military administrative appointments in India should cease when the senior Royal Army Medical Corps officer so incorporated is placed among the lieutenant-colonels selected for promotion.

(d) The nursing sisters of the Q. A. M. N. S. I. should be given the option of permanent service in the Indian Medical Corps. Any further vacancies should be filled as suggested under recruitment.

(e) The following suggestions are made with regard to the military assistant surgeons:—

(1) All further recruitment should cease. This is really inevitable. The raising of the preliminary educational standard and the extension of the period of medical study to 5 years, will enable these men to obtain registrable

medical qualifications, and thereby place commissions in the Indian Medical Corps within their reach. Appointments in the civil medical departments will also be open to them.

- (2) The retirement of military assistant surgeons in military employ at the inception of the Indian Medical Corps should be encouraged by the offering of gratuities.
- (3) Employment for some military assistant surgeons may possibly be found in countries to be developed after the war.
- (4) The surplus can be employed in the Indian Medical Corps on duties similar to those which they are carrying out now. Some of the vacancies caused by retirement will be filled by sub-assistant surgeons, and others by the attachment of recruits for civil medical employment [*vide* para. 6 (b) above on training of war reserve of officers].

8. CONDITIONS OF SERVICE.

The first commission of officers should date from the day on which the list of successful candidates at the entrance examination is published. This should apply to all the medical corps and services of the Empire. This list would then become a guide to the relative seniority of medical officers of equal rank serving in different parts of the Empire.

Promotion.—The following rules are suggested :—

- (a) An officer should be promoted to the rank of captain after the completion of 3 years' service, provided he has passed such qualifying examination as may be in force at the time. Failure to pass this examination in time should ordinarily entail loss of seniority; but the antedating of the promotion of officers, who for unavoidable reasons have been prevented from appearing for the examination within the requisite period, should be at the discretion of the D. G., I. M. C.
- (b) Promotion to major should be after 7 years' service in the rank of captain, provided the officer has passed the qualifying examination.
- (c) Automatic promotion to the rank of lieutenant-colonel after so many years' service should cease. There should be a fixed establishment of lieutenant-colonels, vacancies in which should be filled by selection from among majors, who have passed the qualifying examination.
- (d) The present rules governing accelerated promotion to the rank of major should be abolished, unless they should continue to be in force in the Royal Army Medical Corps.
- (e) Rules for brevet and substantive promotion for distinguished service should be the same as those in force for the army generally.
- (f) The number of major-generals, colonels and lieutenant-colonels in the Indian Medical Corps will necessarily be fixed in accordance with the needs of the army in India: officers of these ranks in civil employ should be supernumerary to the military establishment.
- (g) The tour of duty for administrative medical officers should be limited to 4 years.
- (h) All officers should be compulsorily retired at 55 years of age; but officers who have been pro-

moted to administrative rank may be allowed to serve up to 57 years.

It is suggested that the promotion of officers in civil medical employment be based on the following principles :—

- (a) Officers seconded for a 4 years' tour of duty should be promoted in accordance with the rules in force for the corps generally.
- (b) Officers seconded at the request of local governments, for longer periods than 4 years should be promoted up to the rank of major on the requisite number of years of service. A major should be promoted to lieutenant-colonel when the officer next below him on the active list of the corps has been promoted. Every officer of the rank of lieutenant-colonel, who has completed more than 4 years' continuous (exclusive of leave) service in civil medical employ, should be considered supernumerary to the fixed establishment of this rank in the corps.
- (c) Any vacancy in the fixed establishment of lieutenant-colonels caused by the seconding of an officer of that rank for civil medical employment not exceeding 4 years should be filled by a temporary promotion.
- (d) An officer of or above the rank of lieutenant-colonel, who has completed more than 4 years' continuous (exclusive of leave) service in civil medical employment, should not be recalled to military duty, unless his services be required in times of national emergency.

9. PUBLIC HEALTH SECTION.

It is suggested that within the corps there should be an organized "Public health section."

Attached to every station hospital should be a Public health laboratory staffed by the requisite number of—

- (a) Bacteriologists.
- (b) Pathologists.
- (c) Chemical analysts.
- (d) Public health experts.

In the case of smaller hospitals (a) and (b) on the one hand and (c) and (d) on the other might be respectively combined in one officer.

The whole section should work under a colonel, Indian Medical Corps, who should be on the staff of the D. G., I. M. C., and be designated A. D. M. S. (Public Health). It is suggested that he takes the place of the sanitary commissioner with the Government of India. The health of the army is closely connected with that of the civil population. As it is probable that in future the civil sanitary department will be recruited locally, it is important, with a view to provide a link between military and civil public health measures, that the sanitary adviser of the Government of India should be the head of the military public health section.

On the staff of every A. D. M. S. of a Division should be a D. A. D. M. S. (Public Health). An officer of the rank of lieutenant-colonel should hold this appointment as a rule: if, however, it be found necessary to appoint temporarily an officer junior to that rank, he should be given the local rank of lieutenant-colonel, without the extra salary.

It is suggested that "specialist" and "charge" allowances be abolished.

Memorandum, dated the 8th April, 1919, by Lieutenant-Colonel W. F. Harvey, M.B., I.M.S., Director, Central Research Institute, Kasauli, on the Sanitary and Bacteriological Services.

The Sanitary and Bacteriological Departments have representation on both the military and the civil side of the State medical service. This fact should be kept well in mind in any scheme of re-organization. Free interchange, both of men and ideas, between the military and civil sections of the service should be aimed at in any scheme of re-organization. The same guiding principle should apply to the departments themselves. There is the closest possible relationship between them in aim and in practice, although each department requires a special type of training to fit an

individual for it, which prevents the possibility of complete amalgamation. Nevertheless the work of the two departments is highly inter-dependent. This interdependence is a fact which should likewise be recognised in any scheme of re-organization.

1. Relation of civil to military sections.

The relation of these two sections will be affected by the decisions come to regarding the whole question of transference of officers from military employment

to civil and back again. I assume that one single medical service will be that most likely to be adopted for India; at all events that such an arrangement is the one which would be best for India is the view to which I adhere. It is very essential that some sort of uniformity should exist as regards the time at which transfers should take place from military to civil employ so as to avoid the present anomalies due to the fact that seniority in civil employ is dependent, not on service seniority, but upon the date of joining the new appointment. I would suggest that all military medical officers be given the option of taking up civil employment at or about 5 years' service, and that seniority for those accepting the offer should be that of the date of their commission. In the event of an officer electing to remain in military service at this time and joining civil employ later, he would, in that case, take his seniority as from the date of joining only. The suggestion that the offer of civil employ should be made at 5 years' service would be an innovation, as a military medical officer is entitled to take it at any time after two years' service, if available. I think that a period of 5 years' military service would be an advantage to an officer, and if all alike were subjected to this condition there would be no cause for discontent. At the same time I should strongly recommend that an officer should, in any scheme of re-organization, and to a much greater extent than heretofore, be given definite opportunities during his military service of becoming well acquainted with that side of his work which he intends to make his own in civil employ. The would-be civil surgeon should be given facilities for seeing and even doing civil surgeon's work in his particular neighbourhood. So with the would-be sanitarian and bacteriologist. Both sanitarian and bacteriologist would be given facilities for the procural of the public health diploma, if not already acquired. This brings me to the proposition that one of the functions laid down for all officers should be that of teaching. It only requires that this view be accepted to have it made obligatory on officers. I am convinced that on these lines the probationary period even of five years in military employ would be made easy and profitable for the candidate, and would at the same time make for efficiency in the teaching. Although in most cases the facilities given would be limited to an immediate neighbourhood, arrangements could also be made to extend the privileges to more distant educational centres.

The officer in civil employ should in my opinion be regarded, as heretofore, as a military reservist in the event of war. In order that he should remain efficient it is essential that he should undergo a period or periods of training during his continuance in civil employ. I consider that it would be advantageous to lay down one period for this purpose of six months to be taken at or about 15 years' service, and another of three months at 25 years' service. The latter would apply to officers electing to revert to military service ultimately with a view to acceptance of administrative military appointments. The decision to accept or forego such appointments would be made at the usual stage in the officer's career. In the case, at all events of the earlier of these two periods of training, the actual work for which an officer was more suited would be kept strictly in the foreground. The sanitarian and the bacteriologist would be employed to as large an extent as possible in this period on sanitary and bacteriological duties, always remembering that the bacteriologist is frequently both a sanitarian and a bacteriologist.

2. Recruitment.

The Sanitary and Bacteriological services are at present recruited in India, that is to say, Indian Medical Service officers are admitted to these services, after their period of military training, while Indians who are not Indian Medical Service officers are taken into the departments in India. In the future it is almost certain that there will be great extensions of the aspect of medicine which is called preventive. This will demand a very great increase in members of the sanitary and bacteriological services. The bacteriological service centres around the laboratory and will have its own special type of worker. The

sanitary service is essentially a district department and would have a much larger range in the type of function performed by its workers, and therefore would admit of greater variation in the qualifications admissible for its officer appointments. For the higher appointments in both departments the re-organized Indian Medical Service would supply the greater number of incumbents. This proposition would still be in keeping with the idea that the admission of Indians to a greater share in the higher appointments of State should be kept well in the foreground. The re-organized Indian Medical Service as a whole is to contain a very definitely larger proportion of Indians in its ranks. Then again, with the establishment of schools of tropical medicine and hygiene, which are essentially post-graduate schools the supply of a really good class of candidate for bacteriological and sanitary posts should be assured. It cannot be sufficiently emphasized that the choice of a candidate who desires to go in for the work of preventive medicine should be very carefully made in the first instance. Much greater certainty in this choice will be attained than heretofore with the help of the tropical schools.

Those students of these schools who have passed on to higher work in the school laboratories will come very directly under the eye of their teachers. In this way a much truer opinion of the worth of the individual, his originality, his critical power and his application will be able to be formed than one which is based on examination results alone. As regards the posts which are likely to be open to candidates, what might be characterized as the lesser posts of the Sanitary and Bacteriological Departments would be those connected with municipalities and districts. One would wish that every large town in India had its municipal laboratory. In the larger towns the bacteriologist and the medical officer of health would be separate individuals. In the smaller towns the medical officer of health would combine both functions. Such laboratories would be of extreme importance in co-ordinated schemes' research, such as are certain to be initiated for the study of problems of disease and disability due to sickness. A certain number of promotions from these lesser posts would be made to the higher appointments in the two departments. Certain special appointments involving special knowledge—protozoology, entomology, helminthology, chemistry, etc.—might, if suitable candidates were not forthcoming in India, and there was from the nature and pay of the appointment a likelihood that they would attract outsiders, be thrown open to the most suitable applicant obtainable.

Medical officers of health and district medical officers would be of great assistance to sanitary commissioners and deputy sanitary commissioners. In the case of laboratories and for field bacteriological work it is of the utmost importance that the superior officer should have abundance of assistance for the more routine type of work which is carried on in the laboratory. In almost all cases the superior officer, once trained, should be a supervising officer, except for his own special research or for the particular administrative work which must be done by him. The point which I am endeavouring to make is that it would be profitable to free superior officers for the higher types of work, rather than multiply the numbers of such officers in order to combine routine and research work. For the furtherance of this subject it is desirable that greater numbers of assistant surgeons and sub-assistant surgeons should be definitely admitted to the department. There is a certain small number of assistant surgeons (military or civil) and of sub-assistant surgeons in the department already, or, as the case may be, lent to the department. I would advocate a considerable increase in their numbers and their definite appointments to the department. A certain number of the lesser posts which have been referred to in the Sanitary Department might likewise be opened to such officers.

Thus the recruitment for the sanitary and bacteriological services would include:—

I.—Superior posts.

1. Indian Medical Service officers.

- II.—*Lesser posts.*

- ### 3. Appointments.

4. Qualifications.

5. Pay and fees.

1. *Assistant surgeons*.—I consider that no differentiation need be made between the military and civil assistant surgeons as regards the pay proposed or posts for which they are eligible. The seniority of each would count from date of joining. In the case of assistant surgeons I consider it wholly undesirable that they should engage in private practice but at the same time they should be compensated for the deprivation of it. I consider likewise that as these men would be specially selected, their pay in the department would be at an enhanced rate over that of say civil assistant surgeon. I give in the accompanying table proposals for pay of assistant surgeons to include civil and military.

Grade.	Present pay as civil assistant surgeon.	Proposed pay in Sanitary and Bacteriological Departments.	Compensation for deprivation of private practice.	TOTAL.
	Rs.	Rs.	Rs.	Rs.
3rd . . .	100	150	100	250
2nd . . .	150	225	150	375
1st . . .	200	300	200	500
Senior . .	300	450	300	750

Such terms should attract a very good class of assistant surgeon. It would be advisable to exempt assistant surgeons joining the Sanitary and Bacteriological Departments from the usual grade examinations, many of the subjects of which would have no connection with their work. It might, however, be necessary to substitute some modification of these examinations to meet their special case.

2. *Sub-assistant surgeons.*—The same remarks apply to this class of officers in the matter of private practice, seniority, and exemption from grade examinations as to the assistant surgeons. I give in the accompanying table proposals for pay of sub-assistant surgeons to include both civil and military.

Grade.	Present pay as military sub-assistant surgeon.	Proposed pay in the Sanitary and Bacteriological Departments.	Compensation for deprivation of private practice.	TOTAL.
	Rs.	Rs. A.	Rs. A.	Rs. A.
4th . . .	60	90 0 }		140 0
3rd . . .	75	102 8 }	50 0 }	152 8
2nd . . .	95	142 8 }	75 0 }	217 8
1st . . .	110	165 0 }		240
Senior grade 2nd	125	187 8 }		290 0
Senior grade 1st	140	210 0 }	102 8 }	312 8

6. Instruction.

The institution of Tropical Schools in India will afford what is undoubtedly very necessary instruction in medicine and hygiene. But it is desirable that staff colleges should be established which should supply an education which is specially required of a military medical officer. Suitable localities for such colleges would be Poona and Lucknow. Special courses could also be arranged at these colleges for military assistant surgeons and sub-assistant surgeons. The course of the staff colleges would wholly replace, as far as the Indian Medical Service officer of the re-organized service is concerned, the present course at the Royal Army Medical College at Millbank.

Study leave when taken in India would, to a very large extent, centre around the Tropical Schools. Courses, however, at the larger laboratories would also be included in the scheme of study leave. Study leave would not, however, be confined to India, as there is no question of the great benefit derived from study while on furlough in Great Britain. The

continuance of the present facilities for study leave is strongly to be recommended. The advantage to the State of encouraging this type of study is very great indeed. Study leave facilities should be extended to the fullest extent possible, and particularly extended to the assistant surgeon and sub-assistant surgeon classes as well as the commissioned officer.

Closely connected with this question of study leave is that which is considered in the next and final paragraph.

7. Publication and meeting.

I do not think there is any research worker who has not felt the advantage and stimulus of meeting with his fellow workers. The point at issue, however, it seems to me, is the extent to which the encouragement of meeting would repay the State. I personally consider that it would fully repay the State. It would happen occasionally, of course, that such meeting proved fruitless or that the result did not justify the expenditure. But in spite of these happenings I believe that the advantages outweigh the disadvantages. The meetings of the heads of departments and of juniors in departments with each other should be facilitated. The meeting for consultation of field workers with teachers and directors would be beneficial to both parties. This idea should be definitely considered as one having a foremost place in a scheme of re-organization affecting the Bacteriological and Sanitary Departments. Meetings are most useful for the interchange of ideas, for affording assistance in work, and in publication of the results of work, for the suggestion of control experiments, for the elimination of the unnecessary in work and in many other ways.

The publication of work done is of very special value. It encourages the individual and assists greatly in the dissemination of knowledge of methods and ideas. It serves to demonstrate, from the State point of view, that investigation of State problems in the prevention of disease is active and alert. Much that could be published is never published either because it is considered to be of too little consequence, or because of want of help in preparation, or from indifference. The Indian Research Fund Association made a great step forward in this direction, by the establishment of their journal. I think that an extension of the scope of the journal so as to constitute a truer State Medical Journal with its research and other sections would be a very desirable step to take.

Memorandum, dated the 15th April, 1919, by D. A. Turkhud, M.B., C.M. (Edin.), Officiating Assistant Director, Bombay Bacteriological Laboratory, Parel, Bombay.

I have to express deep regret at not being able to submit my views earlier than this. I had, in the first place, no knowledge as regards the military organization of the Royal Army Medical Corps or the Indian Medical Service, and moreover a considerable amount of thinking and enquiries were necessary before I could adequately answer the questions* asked.

In submitting the following replies I have considered the questions chiefly from the educational, sanitary and bacteriological aspects of the medical services:—

1. I have no knowledge of the military organization of the Royal Army Medical Corps and the Indian Medical Service, but I am of opinion that the military medical service in India should be quite distinct from the civil medical service. I am not in favour of any of the schemes suggested; the scheme C aims, it is true, at two separate organizations, but they are inter-dependent and therefore not two absolutely separate or independent organizations. The military medical service should be purely for the purpose of looking after the welfare of the British and Indian troops in times of peace and war, and should of course fulfil all the requirements of the War Office.

The civil medical service on the other hand should be absolutely independent of the military medical service. The civil medical service which is necessary

for the requirements of the civil Government and of the civil population should provide:—

- (1) Professors and teachers for the teaching of medical science.
- (2) District medical officers, civil surgeons and assistant surgeons.
- (3) Officers for the Departments of Public Health and Bacteriology.
- (4) Officers for the Department of Medical Research.

In Great Britain and Ireland the professors of medical schools and colleges, medical officers of health, and directors of research institutes, have no connection whatsoever with the Royal Army Medical Corps; and there is no reason why there should not exist in India also a highly qualified civil medical service quite independent of the military medical service.

2. As I have stated before I do not know what the requirements of the War Office are, but the purely military medical service should be so constituted as to meet the approval of the War Office, and also the needs of the army in India.

3. Hitherto the military medical services have not attracted the best men from the universities and medical colleges. What this is due to I am unable to say, but every effort should be made—whether by an

* Questions for witnesses.

increase of pay, or other means—to secure the best medical men for the civil medical service. The selection of men by examination may suit the requirements of the military medical service, but for the teaching of medical sciences, and for holding appointments in the Sanitary and Bacteriological Departments and for research work, men can never be selected by examinations, but only by the work actually previously done by them.

4. I do not think that any serious results have followed or are ever likely to follow, by the withdrawal of European medical officers from civil districts or jails in India. Assistant surgeons attached to civil hospitals are quite competent to carry or these duties. There should, however, be ample facilities for such civil medical officers to undergo from time to time post-graduate courses in the presidency medical colleges in medicine, surgery, midwifery, gynaecology, ophthalmology, etc. Post-graduate teaching should exist also at the schools of tropical medicine for those employed in the Sanitary and Bacteriological Departments.

5. The civil medical service should be adequately staffed by well qualified men to meet all the needs of the civil administration in India. Such a civil medical service should not be affected by the needs occasioned by an ordinary war. Wars of the magnitude of the last great War are not likely to occur probably even once in two or three hundred years.

6 and 7. I do not know what reserve is required for military purposes; but I understand that the reserve hitherto held in connection with the Royal Army Medical Corps has proved adequate in ordinary wars without being posted to medical duties in civil administration. During the late War when the services of the civil medical men were urgently required for military purposes, such men, both in England and America, with a little preliminary training, were soon transformed into capable military medical officers. Similarly temporary Indian medical officers also proved very useful after a short military training. There appears to be no reason therefore why a large reserve of medical men is necessary for military purposes, or that such a reserve should monopolize the civil medical service.

8. Ordinary wars do not appear to have affected the civil side of the Indian Medical Service.

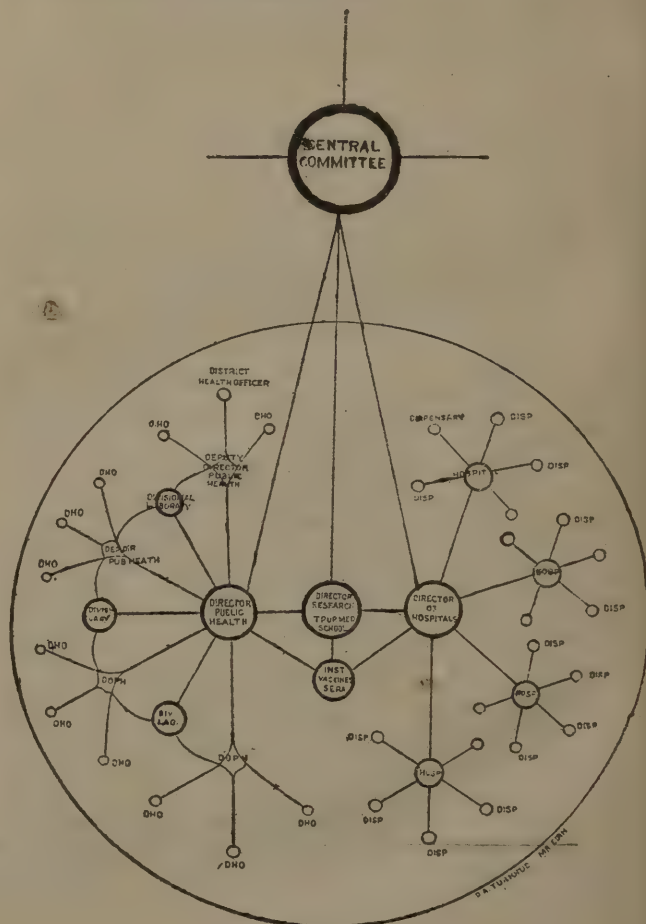
9. Recruitment by examination will prove most unsatisfactory for the purpose of securing the best men in the departments of medical education, public health, bacteriology and research. Professors in all medical colleges and schools of tropical medicine, as well as the officers of the departments of public health and medical research, who should all be men of world-wide reputation, should be specially selected, irrespective of their caste, creed or nationality. Their selection should be entrusted to a well-known body of scientific experts such as the Royal Society of London. There should be in every presidency in India a number of medical colleges, all equipped in a thoroughly up-to-date fashion and all staffed by well-known professors, each a specialist in his own branch. In the Bombay presidency the existing medical schools at Poona, Ahmedabad and Hyderabad, should be converted into fully equipped colleges for the teaching of medicine up to the highest university standard. The class of sub-assistant surgeons should be done away with, and all district dispensaries should be placed in charge of well-qualified assistant surgeons. All civil hospitals should be overhauled and equipped in a thoroughly up-to-date manner as regards the staff and medical, surgical, and laboratory equipments.

As regards the recruitment of men for the civil medical service, every effort should be made to secure the best men turned out by all medical colleges and universities. This, in my opinion, could be best carried out by means of preliminary nomination of men by the heads of medical colleges and universities and their subsequent selection by a special committee or board.

10. Study leave is most important; it is imperative that special facilities should always exist for medical men in civil employ, for undergoing special post-graduate courses from time to time, to enable them to keep themselves in touch with the advance of medical science in all its branches, such as tropical

medicine, surgery, midwifery, ophthalmology, etc. Such post-graduate classes should be held in the presidency medical colleges and also in schools of tropical medicine. It is of the utmost importance therefore that all professorial appointments for teaching purposes should always be held by specialists of world-wide reputation. The practice of appointing any man to any professorship, irrespective of his claims for holding such an appointment, should never be allowed. Professors should not be permitted to degenerate into ordinary general practitioners; they should be allowed to be engaged in consulting practice only. Special facilities should exist for professors also to obtain study-leave and keep themselves up-to-date in their own special branches by visiting the various European or American clinics and laboratories.

11. In these days when medical research has attained such great importance and specialization, a department of research is absolutely necessary. It is expected that each college professor will be provided in his own college with a department of his own equipped with up-to-date requirements and suitable laboratories, where he will carry on independent researches in his own special subject. But in addition to this, there will still remain a considerable amount of important research work to be done in connection with various tropical diseases, and the insects and other carriers which play an important part in the spread of these diseases. Such research work should be carried out by the schools of tropical medicine. There should be at least three or four such schools in India—one for each presidency—and staffed by professors of world-wide renown. The various professors attached to these schools should be given every facility for carrying on their research work. Attached to every school of tropical medicine there should also be a department for training graduates in public health, and an institute for the preparation of vaccines and sera. The various hospitals in the presidency should also be in touch with the school. In this connection I submit herewith a diagram which I prepared in association with Colonel Liston when I was invited to state my views on the subject of public health and bacteriology at the special conference held at Delhi, in December, 1918. This diagram represents in a graphic manner how such special research work can be co-ordinated with the presidency hospitals and also with the Department of Public Health.



12. If private practice of the men in the Indian Medical Service has declined it is where inferior men in the service have to compete with non-service men of superior abilities; service men with special qualifications and high abilities need not have the slightest fear of their private practice declining as the following examples will show. Only recently, professors from some of the medical schools in London acquired quite a lucrative consulting practice during the short

time that they were stationed in Bombay. A well-known retired officer of the Indian Medical Service secured again a large consulting practice on his return to Bombay during the late War. A certain well-known private medical practitioner in a distant corner of the Bombay presidency, draws his vast clientele practically from every district in the presidency. Why do the adjoining civil hospitals fail to do the same?

Memorandum, dated the 4th April, 1919, by Miss A. M. Waterhouse, R.R.C., Chief Lady Superintendent, Queen Alexandra's Military Nursing Service for India, on the future of the Military Nursing Service of India.

Two questions have to be considered:—

- (1) The re-organization of the service, and
- (2) A substantial increase in the establishment.

The entire re-organization of the Queen Alexandra's Military Nursing Service in India has become essential in the interests of general efficiency. But the nursing situation in India is full of problems at the present time and the whole question requires very careful consideration before any steps can be taken.

2. The demands made upon the nursing staff of a station hospital 28 years ago were very small compared with the requirements of the present time. From 1891 to 1901 the nurses worked in one or at the most two wards, known as "sisters' wards," where the cases requiring special nursing were concentrated; they were located at very few stations, and the staffs varied from 3 to 5. In 1907 nurses had been gradually increased to 91 and they were located in 20 stations, the nursing staffs varying from 3 to 7.

3. During the war the number of station hospitals where nurses are employed has been increased to 36 and the staffs increased, as far as accommodation could be arranged, in order to provide nursing for as many patients as possible. In some hospitals the nurses have taken over all the general wards; in others, as many wards as the available staff would allow.

4. From 1887-1902, the service was feeling its way, and the type of nurses selected were chiefly experienced women and the age limit was 35. It was not then intended to retain nurses for more than three periods of service. Later, there was difficulty in obtaining suitable candidates and some not very desirable nurses obtained admission. These were followed by a good many very nice women who proved wholly unsuitable for the duties and responsibilities of the service, and who thought more of their social status than their profession as nurses. The result was deterioration in the general efficiency of the service. Early in 1914 an attempt was made to raise the standard of nursing, alter the existing state of indiscipline, and place the junior nurses under the authority of the seniors, but the war put a stop to any further action in this direction.

5. The war has, however, been the means of making the majority of our nursing sisters, who have worked in France, Mesopotamia and war hospitals in India, realize the necessity of a re-organized service and a higher standard of efficiency both as regards nursing and discipline.

6. Some very special points to be fully considered before any scheme for re-organization can be formulated are:—

Discipline.—Discipline is absolutely essential in the interests of efficiency in the nursing service.

The modern woman.—The average "modern woman" (though a keen worker) thinks much more of her independence of action and her pleasures than the type of woman who took up nursing 20 years ago. The present equality of the "nursing sister" grade tends to friction and indiscipline.

Professional efficiency.—A nurse who serves continuously in India many years has little opportunity (often no incentive) of maintaining a high standard of efficiency. A young nurse leaves her training school, joins her appointment in India, serves for 5 years in a station hospital (or perhaps two hospitals), divides her time between routine duties and social pleasures, is re-engaged for a further period of service and is granted one year's furlough *ex* India, which is pure holiday; returns to India to begin her seventh year

after joining and takes up the threads where she left off. She may be sent to a busy station—or to a "backwater." In any case, she has no chance of keeping apace with modern methods in medical or surgical nursing. The medical or surgical specialist naturally prefers the junior, recently joined, to work for him and frequently objects to the nurse in her second or third period of service because, although she may be a good nurse, she is not "up to date."

Health.—The average woman is able to stand the first 5 years in India fairly well. But many nurses feel the effects of the Indian climate soon after their return for a second period. In this of course the individual counts. Some feel the strain, but carry on their duties well, others though not ill are always ailing, and in consequence these have the monopoly of privilege leave and hill duty to the disadvantage of the stronger ones who need change equally to keep them fit, but have to give way to the "ailing." It is extremely difficult to deal with these "ailing" nursing sisters. The personal element and local conditions are big factors in each case.

7. To maintain an efficient, up to date nursing service in India, frequent new blood is essential. And, if it were possible, I know of no better way to obtain this than by the amalgamation of Queen Alexandra's Imperial and the Indian Military Nursing Services. This would ensure energetic, up to date nurses, and greater physical fitness. They would serve in India for a definite period, and return to England for leave and duty before serving overseas again—as British service nurses do in South Africa, Egypt and Malta, etc., in peace time. It would avoid batches of twelve or more nurses being absent for a year on furlough *ex* India without replacements.

Nurses physically unfit for India would be useful members of the service in Europe and could be transferred.

8. If this is not considered a feasible suggestion, then the Queen Alexandra's Military Nursing Service for India should be entirely re-organized and brought up to the British standard. Nurses should be appointed for the first five years in the grade of "staff nurse," and only those physically fit to stand the climate of India should be considered for retention and promotion to the grade of "sister."

9. The grade of "senior nursing sister" should be abolished, and the grade of "matron" substituted. The promotion of sister to matron should be decided by the Nursing Board, entirely on the general merit and suitability of the nurse, quite apart from seniority. There are many seniors who are excellent nurses but are temperamentally unfit to be in authority over other women. Lady superintendents of circles should be abolished and should be replaced by divisional matrons.

Senior matrons.—A senior matron should be located at each of the divisional headquarter stations, she should advise the divisional authorities regarding all matters concerning nursing arrangements in the division. She should be in direct touch with the matrons of the out stations within the division and should visit them as considered necessary by the Deputy or Assistant Director of Medical Services.

Matrons to be in nursing charge at all first and second class stations where senior matrons are not located, and charge sisters as acting matrons at third class stations, etc. A Chief Lady Superintendent, with a Principal Matron to assist her, should be permanently located at Army Headquarters, India. The lady nurses elected for principal matron should, as a rule, be the next for promotion to Chief Lady

Superintendent. The duties and responsibilities of nurses of all grades should be brought up to the British service standard.

10. *Furlough and medical certificate leave ex India.*—I would suggest that a reserve of 12 nurses should be added to the minimum requirements of the service to allow furlough *ex India*. In the past owing to shortage of staff and the number of nurses absent on furlough and medical certificate leave *ex India*, two nurses have frequently had to carry on for considerable periods and through the hot weather.

11. I also consider that three months of the year's furlough, after 5 and 10 years' service, should be spent in a hospital in the United Kingdom (or colony of

domicile) "rubbing up." That full pay should be granted for this period, and that the year should date from arrival in and departure from the United Kingdom or the country where their leave is spent.

12. Whatever system of re-organization is decided upon, whether the Queen Alexandra's Military Nursing Service for India maintains a separate existence or whether it is amalgamated with the Home nursing service, a substantial increase in the numbers of nurses will be needed. In view of the many questions of military medical administration in India which are now under consideration, it is impossible to give definite information as to numbers, and, as a provisional basis, war time experience in British station hospitals in India forms the only guide.

Memorandum, dated the 25th March, 1919, by Dr. M. I. Balfour, M.B., Women's Medical Service, Joint Secretary, National Association for supplying female medical aid to the women of India.

THE FUTURE OF THE WOMEN'S MEDICAL SERVICE.

The employment of medical women in India outside missionary work was begun by the Countess of Dufferin's Fund in 1885, as a sort of organizing agency bringing medical women from England into touch with municipalities and committees in India, who employed them on small salaries, usually about Rs. 300 per mensem. There were no arrangements for furlough or pensions, and in many cases the women were treated as assistants or as subordinates. In most cases therefore, the women doctors who came out were either not the best type of their profession, or if they were, they left the country dissatisfied after a few years' service. This had its effect on the subordinate women medical workers who were found to be, many of them, of poor attainments especially in midwifery and gynaecology, and whose characters left much to be desired; so that the better class of Indian women shunned the medical profession.

This state of things began to attract public attention in the early years of the present century. In 1909 a deputation of medical women in India met the Central Committee and stated the position very much as above noted. But the Central Committee, partly as a result of this and other representations, applied to Government for a grant to improve the position of medical women in India. In 1911 an influential deputation in England waited on the Secretary of State, Lord Crewe, and laid before him a scheme for a Government service for women doctors in India on the lines of the Indian Medical Service. The final result of these measures was that the Government of India offered an annual grant of one and a half lakhs of rupees to the Central Committee of the Countess of Dufferin's Fund, to organise and carry on a Women's Medical Service for India. This was accepted by the Central Committee and the Service was opened in 1914. Medical women in the United Kingdom and in India welcomed this proceeding as an advance, but expressed disapproval of several of the conditions under which the service was formed. A certain number of capable women doctors working under the old conditions in India agreed to join, but up to the present time only one recruit has been received from the United Kingdom. How far this is due to war conditions and how far to dissatisfaction with the conditions, remains to be seen.

The causes for dissatisfaction are briefly:—

1. Lack of official status.
2. Inadequate pay in the higher grades.
3. Lack of pension.

1. (a) The Service is administered by the Central Committee of the Countess of Dufferin's Fund, of which the Viceroy's wife and the Surgeon to the Viceroy are *ex-officio* President and Honorary Secretary. Formerly most of the secretarial work was carried on by lay secretaries. Since 1916, a medical woman has been appointed Joint Secretary. She supervises secretarial work, and also inspects hospitals and medical institutions under members of the Service in a manner similar to that done by the Director-General, Indian Medical Service, for institutions under the Indian Medical Service. She has however, no official title indicating that she is other than a Secretary. She

is not a member of the Central Committee and has no vote at its meetings. Her influence and authority depend on the powers which the Central Committee may from time to time be prepared to give her, and which would naturally vary very much with the sympathy the individual Lady President might have for medical women.

(b) As the Women's Medical Service is not a Government service, the members have no official position and are not mentioned in the tables of precedence issued by the Government of India. At any official function where ladies are present, they are liable to be placed below the youngest debutante whose father holds an official position, no matter how responsible their work may be. In a country like India where Europeans and Indians alike lay great stress on official rank this is a serious drawback.

2. The pay rises from Rs. 350 to Rs. 550 after ten years' service and thereafter there is no increase. Private practice is allowed, but it is very uncertain, and is becoming less rather than more, owing to the increase of subordinate workers; and the tendency on the part of hospital committees to provide comfortable private wards for better class people, for which rent is charged by the Hospital Committee but no fee allowed for the doctor.

3. Instead of a pension there is a small provident fund. It has been said that this is more favourable to the members of the service than a pension, as it makes it easier for them to retire early. However that may be, there can be no doubt that it is fatal to the interest of a women's service. Women workers have a certain tendency to leave off work after 10 or 15 years, perhaps in order to marry, or for some other cause. In the case of medical women (and those the most capable) they often desire, having gained experience, to return and practise in England. To encourage this tendency will be fatal to the service which above all else needs capable and experienced women to fill the senior posts and the administrative and teaching posts. At present if a member of the service is to live with any approach to comfort after her retirement, she must save a considerable portion of her salary. This is impossible at the present rate of pay.

THE PROPOSED REMEDY.

1. A women's branch of the Indian Medical Service.
2. The members to be without military titles, but to be graded for order of precedence with the officers of the Indian Medical Service.
3. The duties to be considerably wider than at present.

- (a) Sanitary work including maternity and child welfare.
- (b) School medical inspection.
- (c) Educational work, especially in midwifery and gynaecology.
- (d) Administrative work for women's medical institutions.
- (e) Recent experiences have shown that medical women can be used as a reserve in war time.

4. Pay would be on the principle of equal work, equal pay independent of sex.

5. Pension, leave, etc., as in the Indian Medical Service.

6. Administration by the Director-General, Indian Medical Service, with a medical woman as Deputy Director-General, Indian Medical Service, for the Women's Branch.

In connection with a Women's Medical Service, a thing to be considered is the hard condition of European women who have no adequate attendance at their confinements and for gynaecological trouble. The condition is equally hard for Indian women, but they are not aware of the fact as European women are. Very sad cases have been related to me in different parts of the country. Many women in the mufassil have either to leave home for their confinements or submit to attendance by Indian doctors inexperienced in midwifery. This is not in my opinion so much a racial question but owes its hardship to the fact that owing

to the conditions of the country, male medical students cannot get the necessary practical instruction, nor male doctors, except in a few cases, the constant practice afterwards necessary for obstetric skill; nor will they do so until the feeling of the bulk of the women of the country has completely changed as to desire male attendance at confinements. The increase of male medical students will only increase the difficulty. The remedy is to supply a larger number of women doctors in mufassil stations.

In conclusion I may say that for some years past, I have travelled extensively in India, and have studied with interest in all parts of India efforts made to improve sanitation and maternity work. The result has been to impress on me the gigantic nature of the task, and the large sums of money even now wasted on account of ineffective efforts, false starts and especially lack of skilled supervision of otherwise good schemes. I feel sure that conditions of service, improved so as to bring medical women skilled in administration and organising ability into the country, would eventually lead to economy in sanitary efforts in this direction.

Note on the re-organization of the Indian Medical Services, dated the 3rd March, 1919, by Sir F. G. Sly, K.C.S.I.

The four schemes placed before me deal with the re-organization of the medical services mainly from the military side. This may be correct, but so long as civil medical appointments are utilized for the employment of the war reserve, the civil medical requirements must be met. The experience of this war will be valuable in deciding the size of the war reserve and the assistance that can be given by private medical practitioners. A European war of this magnitude, in which the existence of the Empire was at stake, resulted in the willing mobilisation of all the medical forces of Great Britain, but it seems to me doubtful whether a great Asiatic war would make the same appeal to British medical men. On the other hand, the appeal to Indian private practitioners for war service in India or beyond its frontiers may perhaps be greater in an Asiatic war. The need for a nucleus of trained medical officers in the war reserve is obvious, but so far as the civil medical requirements are concerned, it is desirable that this war reserve should be restricted to the smallest limit compatible with military needs. The dislocation of civil medical work caused by the withdrawal of Indian Medical Service officers for war requirements has been very great indeed. The trained reserve should, therefore, be as small as possible and I suggest that it should be supplemented by making it a condition of service in the civil appointments that all officers should be liable for military service in a grave emergency. The first essential of civil medical work is that there should be a body of skilled medical men in a Government service permanently employed in India, so that they may know the habits, customs and languages of the people, and have special knowledge of Indian diseases. I should have thought that this was equally important for the proper medical treatment of Indian troops. Another civil requirement is that the service should include a fair proportion of European medical officers, so that European officers of Government and non-officials may obtain medical treatment from men of their own race. From this point of view, I consider it to be an advantage to maintain a portion of the war reserve in civil employ, for I apprehend that a purely civil medical service must eventually, and perhaps at no distant date, become predominantly Indian.

I fully recognise the advantages that will result from the amalgamation of the Royal Army Medical Corps and the Indian Medical Service into a single corps responsible for both European and Indian troops, and I now proceed to consider the alternative schemes in the light of these preliminary observations.

2. Scheme A contemplates that the military requirements should be wholly met by the Royal Army Medical Corps officers being deputed for tour of service in India. This scheme seems to me self-condemned as unsuitable for the medical needs of Indian troops. Again, it is surely impossible to contemplate that Indian troops should be made over to a medical service, to which Indians will not be admitted. This scheme

contemplates a separate civil medical service, to be recruited partly by the admission of Europeans and Indians through an open competitive examination and partly by seconding officers from the Royal Army Medical Corps for a tour of five years' service in civil employ. The latter method of recruitment would be quite unsuitable for civil requirements. The direct recruits would also form a portion of the war reserve, and would undergo military training in England on appointment, further training on arrival in India, and thereafter six months' military duty, at the end of each succeeding five years' service. These requirements would also dislocate civil medical work, and I have no hesitation in condemning this scheme.

3. Under scheme B, the medical requirements of both Europeans and Indian troops would be taken over by an Indian Medical Service or Corps, to which would be seconded a proportion of Royal Army Medical Corps officers for five years' periods of duty in India. It is not quite clear to me how civil medical needs are to be met under this scheme, but apparently all civil appointments are to be held by this unified corps, officers being posted to them *after* five years' service, and there is to be no separate civil medical services. This scheme seems to me to disregard civil requirements which the Public Services Commission considered to be of great importance. It results in civil needs being unable to create and appoint to medical posts officers other than military service officers. Civil posts will be filled by military officers *after* five years' military service, whereas the civil authorities desire to secure younger men under five years' service, whose most important years of training have not been wholly passed in the narrow medical field of military duty. It disregards the fact that there are several civil appointments recruitment to which should not be restricted to an army service, for instance certain professional, chemical, alienist, bacteriological, sanitary posts and the like. No solution can, in my opinion, be satisfactory to the civil authorities, which does not provide for a separate civil medical service, of which a part but not the whole may be recruited from the military service.

4. Schemes C and D make more attempt to meet the civil medical needs, but are not fully satisfactory from this standpoint. Scheme B contemplates that recruitment to the civil medical service will be restricted to military officers with the addition of promoted civil and military assistant surgeons. Scheme D permits the recruitment, in addition to military officers, of officers selected by open competitive examination, but apparently such examination will be held in England only. This would be unfair to private practitioners in India and there are many specialist appointments for which such a method of recruitment is unsuitable.

5. My examination of these schemes thus leads me to the conclusion that none is so suitable to the civil needs as the proposals made in the report of the Public

Services Commission. A unified medical service for both European and Indian troops may be a great improvement in meeting military requirements, but if the war reserve is to be employed in civil employ, which seems necessary as a measure of economy, the arrangements must provide suitably for the civil needs. And the minimum requirements are those specified in the recommendations of the Public Services' Commission Report. Indeed, in one respect it may be desirable to go even further in limiting the size of the

war reserve to be provided for in civil employ, particularly if such reserve is to be liable to further military training after every period of five years' service. I hold strongly to the view that there should be a separate civil medical service, which may partly be recruited from the military service to form a war reserve, but civil requirements demand that recruitment should not be limited to military officers, particularly for certain specialist branches of the medical administration.

Memorandum, dated the 20th February, 1919, by temporary Colonel W. H. Willcox, C.B., C.M.G., M.D. (Lond.), F.R.C.P. (Lond.), B.Sc. (Lond.), D.P.H. (Lond.), F.I.C., etc., Army Medical Service. Consulting Physician to Mediterranean Expeditionary Force (July 1915 to January 1916) and to Mesopotamian Expeditionary Force (March 1916 to January 29th, 1919). Physician to Out-Patients, St. Mary's Hospital, London, W. Member of the Staff of St. Mary's Hospital, Medical School since 1899. Senior Toxicological Adviser to the Home Office. Formerly Examiner in Forensic Medicine to the Universities of Manchester, Birmingham and Leeds and in the D. P. H. Examination of the Royal College of Physicians, London. Visitor for His Majesty's Privy Council to the Examinations of the Pharmaceutical Society of Great Britain.

MY VIEWS AND OPINIONS REGARDING THE PRESENT AND FUTURE OUTLOOK OF THE INDIAN MEDICAL SERVICE.

I. Introduction.—During the past twenty years, as a lecturer and clinical teacher at St. Mary's Hospital Medical School, London, and also as examiner to various universities, etc., I have been constantly associated with medical students and with a large number of members of the medical profession occupying important positions in civil life and posts in the various medical services.

During the past four years in the course of my military medical duties, I have been constantly associated with very many medical officers of the Royal Army Medical Corps and of the Indian Medical Service in the Dardanelles, Egypt, India and in Mesopotamia and Persia.

In April, 1916, I visited India for three weeks and had the opportunity of inspecting the hospitals in Bombay.

In February, 1919, under orders from the Government of India (No. H.-3501, dated May 3rd, 1916), I visited India and inspected some of the hospitals where sick from overseas were being treated.

On both of my visits to India, I had the privilege of numerous conferences with the Director, Medical Services in India, with the Director-General, Indian Medical Service, and with many other officers of both of these services. I feel that it is necessary that the Committee should know on exactly how much personal knowledge my views are based.

The views I hold are based on the personal experience detailed above.

II. Appreciation of the work done by the Indian Medical Service.—During the war I have seen a great deal of the work done by officers of the Indian Medical Service and I have been greatly impressed by its high standard of excellency.

Officers of this service of a few years standing invariably show a wide practical knowledge of tropical disease and considerable clinical experience. They are also familiar with bacteriological work and the modern scientific methods of investigation. I have especially admired the great professional knowledge combined with a high standard of administrative experience displayed by a great many of the senior members of this service.

I do not know of any other medical service which produces senior men of this type. The reason undoubtedly is that the wide experience gained by Indian Medical Service men in some of the important civil posts held during their career gives them a knowledge and experience which is not to be gained in any other medical service. The late Sir Pardey Lukis—whose memory we all revere—was a distinguished example of the type I have in mind.

In my opinion the experience of Indian Medical Service officers gained in civil appointments, enlarges their breadth of view and professional experience to such an extent that their value in military administrative appointments is greatly enhanced.

It must, however, be borne in mind that it is undesirable for civil to entirely displace military experience in the life work of the Indian Medical Service officer. The two should go hand in hand and periods of military experience should be interwoven with those of

civil, so that at any time the medical officer holding a civil post can be relied upon to be able to efficiently undertake a military post corresponding to his seniority at a moment's notice.

In past years the importance of this co-relationship has to some extent been lost sight of, and the experience of the war has furnished a few examples of the need of more recent military experience of officers who have for long periods held civil posts only.

The high type of medical officer produced by a happy combination of civil and military experience, is to my mind a strong argument in the preservation of the civil side in the future medical service of India.

III. Unpopularity of the Indian Medical Service during recent years.—It is an undoubted fact to my personal knowledge that during the last few years the Indian Medical Service has become extremely unpopular with the medical profession from the point of view of selection of this service for the life career of young medical men.

Up to about 10 years ago the Indian Medical Service was considered one of the most desirable careers for the recently qualified student, and it attracted the very best of those who were desirous of entering one of the public services. Since that time the Indian Medical Service has become increasingly unpopular with the medical student so that at the present time few aspire to join it. The best of the class of students from whom the Indian Medical Service was recruited now enter the Royal Army Medical Corps.

Knowing the great disabilities under which Indian Medical Service men have been faced in recent years (especially since the war), and also the increasing dissatisfaction of members of that service, medical men on the staff of the teaching hospitals at Home have been unable to recommend students to join the service when, as is very frequently the case, they are consulted in the matter.

It is quite certain in my opinion that newly qualified men will not think of entering the Indian Medical Service unless considerable alterations are made so that the service can show such attractions as will compare favourably, for example, with those of the Royal Army Medical Corps.

IV. Improvements of the condition of service for the "individual" Indian Medical Service officers.—These are absolutely necessary, and they must come unless the Indian Medical Service as such is to die a natural death. The improvements necessary have been so fully discussed and threshed out by distinguished officers of the Indian Medical Service of long experience in India, that it is only necessary for me to briefly mention them.

(1) *Increase of pay.*—This is absolutely necessary, and an increase of at least 33½ per cent. must be granted if the service is to be continued. The increased cost of living in India, the low value of the rupee, and the necessity of bringing the rates of pay up to that of other medical services, and other scientific branches of the army, e.g., Royal Army Medical Corps, Royal Engineers, etc., are cogent reasons.

(2) *Leave and study leave.*—It is necessary for arrangements to be made whereby the Indian Medical Service officer can regularly obtain his leave, and study

leave as soon as he is entitled to them. On medical grounds this is most desirable since a high degree of efficiency is incompatible with a long continued residence in the tropical climate of many parts of India.

I have during the last three years met many Indian Medical Service officers who have been unable to obtain leave home for ten years or more. I have not met a single officer who has been able to obtain the full leave to which he is entitled. Very few have been able to obtain the leave which has been sanctioned by regulations.

A free passage home to and from, should be provided by Government for an Indian Medical Service officer and his wife and family at the end of each four years' service in India.

(3) *Promotions*.—It is well known that the opportunities of promotion in the Indian Medical Service have compared very unfavourably with those in the Royal Army Medical Corps. The unfavourable position in this respect of Indian Medical Service officers has been greatly enhanced during the present war and numerous examples have been quoted and a great many have come to my personal notice.

It is most desirable that the conditions as regards promotion should be made to approximate, as far as possible, to those of the Royal Army Medical Corps.

V. *Regarding station hospitals in India for British and Indian soldiers*.—I have read the reports of two committees appointed to consider these questions, namely, the British Station Hospital Committee Report, dated February 12th, 1918, and the Indian Station Hospital Committee Report, dated March 10th, 1918.

I thoroughly approve of the admirable and necessary recommendations made in these reports.

The recommendation of the Indian Station Hospital Committee for the employment of women nurses, is, in my opinion, a very advisable one. It has been my experience in the past war that the employment of women nurses in military hospitals for Indian patients has greatly improved the standard of comfort and medical treatment.

VI. *Special appointments*.—Medical service has become so specialised during recent years that it is very necessary, primarily in the interests of the patients, and secondly in the interests of the education of medical officers, that the future medical service in India should have consulting physicians and surgeons, and in addition consulting specialists in bacteriology, pathology, malariology, epidemiology, ophthalmology, venereal disease, mental disease, forensic medicine, dentistry, laryngology and otology (combined), neurology and electrotherapeutics (combined).

The above appointments should carry with them appropriate rank and pay.

With reference to the appointment of dispensers and compounders in station hospitals, I recommend that a certain number of these appointments be opened to British qualified pharmacists. These men have been of invaluable service as dispensers in the British and Indian stationary and general hospitals during the war to my personal knowledge.

Their appointment will do much to raise the standard of pharmacy in the Indian Medical Service.

A School of Pharmacy should form a part of the function of the Indian Medical Staff College when this is started in India.

VII. *An Indian Medical Service College*.—A Staff College on the lines of the Royal Army Medical College at Millbank would be of enormous value in the education of medical officers and subordinates of the Indian Medical Service. It is to be strongly recommended.

VIII. *Civil employment of Indian Medical Service officers*.—In my opinion it is most desirable that the civil appointments at present held by Indian Medical Service officer should continue to remain open to them. I do not consider that men of adequate professional experience and status could be found to fill these posts except from the medical service in India.

In my judgment there is not a supply of suitable qualified medical men for these posts available in the Empire except from the medical services. In view of the present great shortage of medical men not a fraction of these posts could be suitably filled from outside. It is most desirable, as mentioned in (II) above, that a proper adjustment of the periods of civil and military

employment should be made, so that an Indian Medical Service officer in civil employ should remain efficient for military service when called upon.

I agree with the suggestion that on attaining the rank of lieutenant-colonel an Indian Medical Service officer should decide in which branch—civil or military—he will remain for the rest of his period of service.

The civil branch of the Indian Medical Service under the re-adjustment conditions will always be a good war reserve of medical officers, should occasion arise.

In my opinion, it would be harmful on the grounds of efficiency to India, to start a civil medical service quite separate from the Indian Medical Service; also it would be a great mistake from the point of view of economy, for it would mean the wasteful expense of keeping a large war reserve for purely military Indian Medical Service officers.

IX. *A single Indian Medical Service for India*.—This appears to me to be the most satisfactory solution of a very difficult problem. The dual system of the past has given rise to much rivalry and heart burning, and such a system does not tend to economise in many ways, as in the question of station hospital arrangements.

The single Indian Medical Service might be called the "Royal Indian Medical Corps" should permission be granted for this name—or some other suitable name might be chosen. At its inception, it would be necessary for the "Royal Indian Medical Corps" to include the whole of the Royal Army Medical Corps officers of all ranks at present serving in India. These officers should become permanent officers of the "Royal Indian Medical Corps," and if they are unwilling to join the "Indian Medical Corps" the posts vacated should become open to other medical officers of the Royal Army Medical Corps, of corresponding rank. Once started the vacancies in the "Royal Indian Medical Corps" will be filled by its own officers and junior officers will be recruited from members of the medical profession as heretofore.

All officers of the "Royal Indian Medical Corps" would become permanent officers with continuous service in India, due allowances for leave being, of course, given. In the case of medical officers coming out from the United Kingdom with their battalions, these officers would be given the option of becoming permanent officers of the "Royal Indian Medical Corps" or of being seconded to this corps for service with their battalion for a definite period.

In my opinion a long period of service in India is necessary before a medical officer becomes thoroughly efficient both from a medical and military point of view. On these grounds it is desirable that medical officers of the "Royal Indian Medical Corps" should engage for continuous service in India. The head of the "Royal Indian Medical Corps" would be a Director-General, with direct access to Viceroy and Commander-in-Chief. Immediately under the Director-General would be the Director of Indian Military Medical Services and the Director of Indian Civil Medical Services.

If the conditions of service are made sufficiently attractive on the lines detailed above, it would, in my opinion, be possible to start a "Royal Indian Medical Corps," and recruits would be forthcoming to fill the gaps caused by inevitable vacancies.

It is desirable that the single medical service for India should have a large preponderance of British officers.

This would be brought about in all probability by having an entrance examination of a high standard and practical character.

The essential, of course, is to make the single Indian Medical Service ("Royal Indian Medical Corps") sufficiently attractive to the recently qualified British student.

An alternative scheme for the single Indian Medical Service might be suggested, namely to absorb the present Indian Medical Service into the Royal Army Medical Corps and to make the old service a branch of the Royal Army Medical Corps. There are two difficulties with regard to this, namely, (1) would the Royal Army Medical Corps officer be willing to serve continuously in India for his whole service? and, (2) would the Royal Army Medical Corps admit into its portals Indian

(coloured) members of the present Indian Medical Service and would they be willing to throw open their doors to future Indian candidates?

It is quite certain that, in view of the lines on which Indian political affairs are going, and in view of the recent proposals of the Secretary of State for India, the

retrograde step of refusing admittance of Indian candidates for the single Indian Medical Service would be impossible.

In my opinion this alternative scheme would be an unsatisfactory one and I support the former scheme detailed above.

Letter, dated the 20th February, 1919, from the General Secretary, Bihar Planters' Association, Ltd., Muzaffarpur, to the Secretary, Medical Services Committee.

With reference to your No. 29 of the 4th, I am directed to write you that, in three out of the four districts of the Tirhut division, a European doctor is engaged to attend to medical treatment required by the Bihar planters and their families. There has also usually been an understanding with the civil surgeon, an Indian Medical Service officer, in the head stations, by which the latter will attend to planter patients in cases of necessity when the planters' doctor has to go outside the station.

The reciprocity of services is, you will appreciate, extremely important, and has been found to work satisfactorily.

Should the appointment of medical officers in these districts belonging to the Indian Medical Service be done away with, we are of opinion that such a step

would be viewed with considerable dismay by the European families, as they prefer medical treatment by their own countrymen, there being a strong prejudice against Indian members of the medical service being called, more especially where European women and children are concerned.

It is our opinion that the number of European doctors would not be increased, and, if members of the Indian Medical Service are not employed as civil surgeons of districts, it would tend to a distinct discouragement to Europeans to come to this country to live in the mofussil.

It is also our experience that, in serious cases, it is invariably the custom for well-to-do Indians to call in the Indian Medical Service civil surgeon.

Letter, dated the 25th February, 1919, from the Secretary, United Planters' Association of Southern India, Coimbatore, to the Secretary, Medical Services Committee.

The Chairman of this Association has forwarded me your letter No. 29 of the 4th instant and asked me to reply to same.

1. The following European medical men are employed in connection with estates in Southern India :—

Dr. Milton, residing at Coonoor, Nilgiris, is in charge of the Wynaad Planters' Medical Association and attends on estates situated in the South Wynaad, Malabar.

Dr. Vanderworth, to reside at Valparai, has recently been engaged by the Anamalais Planters' Association, and will attend on all estates in the Anamalais district of Coimbatore. His demobilisation has been promised but he has not yet joined his appointment.

Dr. J. S. Nicholson, residing at Munnar, is the medical officer in charge of the Kanen Devans Planters' Association, and attends on all estates in the Devikolam district of Travancore.

Dr. H. McCormack, residing at Peermade, is medical officer to the combined Mundakayam and Central Travancore Medical Association, and is in medical charge of all estates in the

Mundakayam and Peermade districts of Travancore.

A retired European doctor resides at Yercaud and is at times consulted by the planters of the Shevaroyis, although not regularly employed by them. Other planting districts have their medical funds employing apothecaries and doctors who are not Europeans.

2. With reference to your second para., it is our opinion that as regards mofussil towns the withdrawal of facilities for obtaining medical advice from European officers of the Indian Medical Service would not be followed by an increase in the number of European doctors not in government employ. There is insufficient inducement for medical men to settle in up country stations, and without a fixed salary it is doubtful if any of them could make a living.

My Association views with concern the suggestion that the present very insufficient European medical assistance may be reduced still further, as, at present, in a great number of districts, members of the Indian Medical Service are the only European doctors we can turn to in case of illness of our wives and children.

Letter, dated the 22nd February, 1919, from the Managing Agents, the Howrah-Amta Light Railway Company, Limited, Calcutta, to the Secretary, Medical Services Committee.

With reference to your letter No. 6—13, dated 13th February, 1919, we have the honour to state that no European medical officer is exclusively employed on any of our light railways, but in the cases of certain of the railways a retaining fee is paid to the local Indian Medical Service officer or to the district medical officer.

As to your further enquiry as to the effect of reducing the facilities for obtaining medical advice from Euro-

pean officers of the Indian Medical Service, we should say in the large presidency towns the matter would to some extent be corrected by the attraction of civilian doctors to India under the ordinary working of the laws of supply and demand, but that in the mofussil the reduction of these facilities would result in patients desiring European medical attendance being unable to obtain same.

Letter No. D. H.-132—1, dated the 27th February, 1919, from the Agents, Darjeeling-Himalayan Railway Company, Limited, to the Secretary, Medical Services Committee.

In reply to your letter, dated the 13th instant, we have to inform you that we only pay honorariums to European consulting medical officers, one at Kurseong, the other at Darjeeling.

With regard to the second paragraph of your letter, our opinion is that in the event of facilities for obtain-

ing medical advice from European officers of the Indian Medical Service being considerably reduced, the number of European doctors in India, not in government employ, would not be increased except in the few large Presidency towns.

Letter, dated the 6th February, 1919, from the Secretary, Cambridge Mission, Delhi, to the Secretary, Medical Services Committee.

In answer to your letter No. 30, dated 4th instant, I beg to say that the organization of the Society for the Propagation of the Gospel is entirely diocesan, so that I have not any accurate knowledge as to its work in other dioceses. However, I believe I am correct in stating that the only European medical men employed in India under the Society are (a) under the Dublin University Mission at Hazaribagh, Chota Nagpur, in which I believe there are 2 or 3 male medical missionaries, and (b) in the Tinnevely and Madura diocese, where I believe there is one medical man. The Secretary of the Society for the Propagation of the Gospel in this diocese is at Ramnad.

The latter gentleman, and the Secretary of the Dublin University Mission will be able to give you accurate information with regard to their missions.

2. With regard to the second paragraph of your letter I beg to state that I do not think it is likely that in the

event of facilities for obtaining medical advice from European officers of the Indian Medical Service being considerably reduced, the number of European male doctors in India not in government employ would be at all appreciably increased. I think, however, that the number of women doctors working as private practitioners would be likely to increase, probably in considerable proportion to their present numbers, but not to a large actual number. Such private practitioners, moreover, it may be anticipated, would mostly reside in hill stations during the hot weather.

3. I understand that your enquiry in the first paragraph referred strictly to male medical missionaries. If you desire details as to women medical missionaries employed under this Society, I shall of course be glad to give them for this diocese; for other parts of India it would be better, if accuracy is desired, that direct references should be made to the various diocesan secretaries.

Letter, dated the 10th February, 1919, from the Secretary, Church Missionary Society in the Punjab, North-West Frontier Province and Sindh, Lahore, to the Secretary, Medical Services Committee.

In reply to your letter No. 30, dated 4th February. I give below a list of the European medical men at present belonging to the Punjab Mission of the Church Missionary Society. The Church Missionary Society has no medical missions in other parts of India except one in Bengal.

In regard to your request for my opinion whether, in the event of facilities for obtaining medical advice from European officers of the Indian Medical Service being considerably reduced, the number of European doctors in India in non-government employ would be increased, and if so, to what extent, I have no means of forming any opinion as to how far a larger number of non-missionary European doctors would be attracted to India. It does seem likely, however, that such doctors would have more opportunities if there were fewer civil surgeons. I do not think that reduction in the number of the European officers of the Indian Medical Service would increase the number of medical missionaries. Medical missionaries, though always ready to do what they can for private patients, come out to India specially for missionary work, not only medical but evangelistic. Their number is not in any way affected by the competition of European officers of the Indian Medical Service, but is limited only by the number of doctors who are willing to take up missionary work and by the financial means of the societies which send them. I do not think therefore that Government has any reason to expect that a reduction in the number of their own Indian Medical Service men would increase the number of European missionary doctors.

Enclosure.

List of European men doctors belonging to the Church Missionary Society in the Punjab, North-West Frontier Province and Sindh.

Srinagar, Kashmir	Dr. Arthur Neve, F. R. C. S., L. R. C. P., Edinburgh. (At present on War Service.) Dr. E. F. Neve, M. D., C. M., F. R. C. S., Edinburgh. Dr. C. Somerton Clark, M. B., Ch. B., F. R. C. S., Edinburgh (on furlough).
Dera Ismail Khan	Dr. J. F. Richardson, M. R. C. S., L. R. C. P. (On War Service in Mesopotamia.) Dr. C. Vosper, M. R. C. S., L. R. C. P., London.
Peshawar	Dr. R. J. H. Cox, M. B., B. S., London. Dr. A. C. J. Elwin, P. A., Cambridge, L. M., S. S. A. (On furlough.)
Quetta	Dr. H. T. Holland, M. B., F. R. C. S., Edinburgh. (Temporarily on Government work.) Dr. S. Gaster, M. R. C. S., L. R. C. P., London.

Letter No. 237, dated the 19th February, 1919, from the Secretary, Society for the Propagation of the Gospel in Foreign Parts, Madras Diocesan Committee, Madras, to the Secretary, Medical Services Committee.

Your letter No. 6—1 of the 8th February, 1919, has been forwarded to me from Ramnad. The only European medical man working for this mission is the Rev. Dr. F. Wellis, M. R. C. S., L. R. C. P., who is stationed at Ramnad. He, however, is going on furlough this year and hopes to leave India in the course of the next two months. I have no means of procuring the information of the number of European medical men employed by this Society in other parts of India until the

Society's annual report is issued for the past year. This is not published until May and will reach India about the end of May.

2. I am of opinion that, if medical advice from members of the Indian Medical Service was restricted, the number of European doctors not in government service would not be appreciably increased, for medical men would hardly venture to come out to India on the chance of building up a practice.

Letter, dated the 24th February, 1919, from the General Superintendent, Wesleyan Mission, Bengal, Calcutta, to the Secretary, Medical Services Committee.

With reference to your letter No. 38, dated the 4th February, I have to say that there is only one European medical man at present employed under the Wesleyan Missionary Society in this country.

With regard to section 2 of your letter, I am not quite clear as to its meaning, but I do not think that in the event of facilities for obtaining medical advice from

European officers of the Indian Medical Service being considerably reduced, the number of European doctors in India not in government employ would be increased. I think that any reduction of the number of European officers of the Indian Medical Service would be a most serious matter for the whole community.

Letter, dated the 28th February, 1919, from the Secretary, Society for the Propagation of the Gospel in Foreign Parts, Ranchi (Bihar and Orissa), to the Secretary, Medical Services Committee.

In answer to your No. 30 of 4th instant, I am directed by the Bishop of Chota Nagpur to say—

- (1) that the European medical men employed in this mission are only two at present:—

Rev. K. W. S. Kennedy, M. B., B. Ch., Dublin, and

Rev. A. T. Williams, M. R. C. P. and S.,

- (2) that the reduction of the number of Indian Medical Service European officers would not have any effect in increasing the number in mission employment. Any increase in numbers of medical men in mission employment likely to take place will be in remote and outlying places far from civil stations.

I note that your inquiry does not deal with medical women.

Letter, dated the 11th April, 1919, from the Secretary, Darjeeling Planters' Association, to the Secretary, Medical Services Committee.

Your letter No. 33—2 of the 16th February last and enclosures were laid before a meeting of the Committee of this Association held on the 29th ultimo, when I was directed to inform you that there are as a rule at least two civil doctors in this district, one practising at Kurseong and the other in Darjeeling. As a matter of fact at the present time owing to the recent death of the planters' doctor for this district, a captain of the Royal Army Medical Corps is

attending to urgent cases until a new civil doctor can be appointed; but, this is the first occasion on which the services of a military doctor have had to be called in. So, therefore, this district may be considered as more or less independent of the objects set forth in your letter. My Committee, however, have considered the various schemes, and, are of opinion that scheme 'B' would be the most suitable one for this district.

Letter No. 460—O., dated the 22nd April, 1919, from the Secretary, Indian Tea Association, Calcutta, to the Secretary, Medical Services Committee.

I am directed by the Committee to acknowledge receipt of your letter No. 33—2, dated 16th February, 1919, with its relative accompaniments, in connection with problems under consideration by the Medical Services Committee.

2. The Committee have examined these papers, and they do not propose to offer any detailed criticisms in regard to the points raised therein. I am directed to explain, however, that, generally speaking, so far as medical attendance is concerned, the Indian tea industry is rapidly becoming independent of military medical services.

3. From the point of view of the needs of the industry the Committee regard the establishment of efficient sanitary departments in the provinces as of the utmost importance. The Committee consider that these departments should be closely linked with a research department, so arranged as to avoid duplication of work in the different centres, and they trust that this

matter can be brought within the scope of the general scheme to be formulated for the future organization of the medical services in India.

4. With reference to the enquiry in paragraph 4 of your letter under acknowledgment, regarding the number of European doctors employed on estates connected with the Indian Tea Association, I am directed to subjoin below, the following particulars which have been ascertained from the branches and local associations specified:—

European doctors

(1) Assam Branch, Indian Tea Association	21
(2) Surma Valley Branch Tea Association	11
(3) Dooars Planters' Association	7
(4) Darjeeling Planters' Association	3
(5) Terai Planters' Association	1

TOTAL . 43

A paper on the promotion of hygiene and the prevention of malaria and other diseases by co-operation, contributed by the Hon'ble Mr. P. C. Mitter, C.I.E., for the tenth Bengal Provincial Co-operative Conference.

For a Bengali, and before an audience conversant with Bengal problems, it is hardly necessary to dilate at any length on the insanitary condition of our province. Though we have a fair idea of the general state of the health of Bengal it will perhaps be helpful to place before you some broad facts relating to the sanitary condition of Bengal. Our death-rate in the year ending 1917 was over 26.2 per mille and although this death-rate indicates a slight improvement as compared with the quinquennial death-rate between the years 1912—17—the death-rate of this quinquennial period was 30.2 per mille—yet it must be conceded that a death-rate of 26.2 per mille is fairly unsatisfactory. The death-rate in rural areas is even higher than the aforesaid rate, which is for the province as a whole. The average death-rate from fever alone in rural areas was 20.3 per mille in the year 1917 and in the aforesaid quinquennial period 22.8 per mille. It is well-known that for one that dies many more suffer. This is specially true of malaria-stricken rural areas. Although no statistics are available of the number of people who suffer from fever, yet our experience of such rural areas tells us that perhaps for one man who dies of fever, eight or ten suffer. Then again it is well-known that the death-rate and suffering between October and January are very high as compared with the rest of the year. It is therefore nothing uncommon for us to find in many affected areas that every second or third man suffers from fever during these months.

The man who suffers may escape death even for several years, but malaria leaves behind a dangerous legacy in the shape of an enlarged spleen and a shattered constitution. The man who suffers from chronic malaria may perhaps drag on a miserable existence for a number of years but ceases to be a fit man in every sense of the word. Apart from physical sufferings and miseries attendant upon affliction from malaria the general condition of a society so afflicted must be depressing all round. The effect of wide-spread malaria upon all human activities must be immensely detrimental. If one attempted to calculate the economic loss all over Bengal attributable to malaria I have no doubt the money value would be enormous. I once tried to make an estimate of the annual basic income of all agriculturists in Bengal and I came to the conclusion that fifty crores will perhaps be a fair estimate. If 50 crores be the present annual income of all agriculturists in Bengal I have no doubt that with a Bengal free from malaria that figure will be not less than one hundred and twenty crores. The effect of malaria on the vitality of the people as a whole is represented by the low average (or mean) life of a Bengali which, I believe, is only about 25 years. This figure about the average or mean life of a Bengali is perhaps to some extent misleading but there is another set of figures which is very convincing, e.g., that out of every 1 lakh of males about 71,000 die before 30, about 85,000 die before 40 and about 93,000 die before 50. (See page

281 of Volume V, Part I of the Census of India, 1911.) Such being the conditions of health of the province, is it possible for a people afflicted as we are by malaria and various other preventible diseases to accomplish anything really great? Is it possible for us to undertake successfully any great work of nation building, whether it be education or economic development or political progress? However I began by promising that I would not enter into any detailed examination of the sanitary condition of Bengal, for its unsatisfactory state is well-known to all of you. The more immediate and practical problem is how to remedy this unquestioned evil. It is a practical question which must be solved on practical lines. Some say that the problem can be solved by work on charitable lines; others are of opinion that the problem is so vast that it can only be solved by Government and Government alone. I, however, venture to assert that the problem can never be effectively solved either by charity or by the Government, but it can only be solved by determined work by the people with the co-operation of the Government or of persons charitably inclined. No doubt charitable organizations can do some good. It is equally true that the Government also can do some good. But the resources of charity and the resources at the disposal of the Government are wholly inadequate considering the vastness of the work which lies before us. For rural Bengal alone we have to deal with over 42 millions of people scattered over 68 thousand square miles. Turning first to the possibilities of charitable relief let us consider briefly to what extent charitable relief is available to us. In Indian society there are perhaps only three classes of people from whom one may expect some help on charitable lines, namely, the prosperous landowner, the prosperous business man and the prosperous professional man. Taking landowners first, what do we find? There are at the present moment about 1,34,000 revenue paying and revenue free estates and about 26 lakhs of tenure-holders.* The total rent roll of Bengal (that is, the total amount paid by all *ryots* in Bengal) is about 12½ crores of rupees. The total Government revenue is about 2 crores and 76 lakhs of rupees. The net income therefore of all the landlords of Bengal including by that term tenure-holders as well, is little over nine crores of rupees. The figures I have already given will show that the total number of revenue-paying estates and tenures is little less than 29 lakhs. The net income of a landlord, astounding as it may seem, is only about Rs. 30 a year. If from this we deduct the income of our territorial magnates, our Rajahs and Maharajahs, the average will be even less. It may be said that we are not concerned with the average but we are concerned with the more wealthy landlords. Let us then examine the financial position and the number of the more wealthy landlords. There are between 3 to 4 hundred voters in the electoral roll of land-holders for the Imperial Council. The revenue and cess qualifications will show that every zemindar with a minimum income of about 8 to 9 thousand rupees is likely to be a voter. It is clear therefore that the total number of zemindars with an income of 8 to 9 thousand rupees is less than 400. It is idle, therefore, to expect anything very tangible in the shape of charitable aid from the land-holders. Turning next to the businessmen, the traders and merchants we find that only about 1,200 persons pay income-tax on an income of ten thousand rupees or over. This 1,200 includes professional men as well as businessmen. These men have various calls on their purse and the number quoted above will show that their resources are not such as to allow them to do anything very tangible on charitable lines. Lastly let us take the possibilities of obtaining charitable relief from the professional men. According to the last census table there are about 9,750 lawyers all over Bengal. Revenue agents, muktears and kazis have also been classified under the heading of lawyers. Roughly speaking perhaps about 3,000 are revenue agents, muktears and kazis. The number of other lawyers will therefore be about 6,500. I venture to assert that not more than 10 per cent. make a minimum income of more than Rs. 6,000 or Rs. 7,000 a year. The possibilities of substantial relief from the lawyers are therefore not very hopeful. There are about 3,000 medical men registered under the Medical Act of 1914. A fairly large number of these are medical men who have passed from medical schools

and are not medical graduates. Generally speaking the average medical man does not make a large income. The men at the top may do, but their number is comparatively small. The above facts ought to satisfy any one that even if all prosperous men were very very charitably inclined it would be extremely difficult to raise annually anything more than half a lakh of rupees from the whole province. But what will half a lakh or even a lakh do if we have to provide charitable organizations for a province whose area is 68,000 square miles and whose population is 42 millions?

Let us next consider the possibilities of Government action for solving this problem. It appears from the accounts of the Bengal Government that in the year 1916-17 the Government could spend only 4 lakhs of rupees under the head of "Sanitation" and about 23½ lakhs of rupees under the head "Medical." There are no doubt other indirect expenses not included in either of these two heads. Last year the Government had increased their expenditure on sanitation. Perhaps this year the Government will increase the expenditure on sanitation still more. But what will a few lakhs do for any effective solution of the vast problem before us? Those who are familiar with the budget figures of the Bengal Government know very well how difficult it is for the Government to set apart any very substantial sum for sanitation. So that with the best of intentions it is hardly possible for the Government to spend anything very effective for extensive organized work for the improvement of sanitation.

Paradoxical though it may seem, what is so difficult for the wealthy few, what is so difficult for a powerful Government to successfully undertake, it is comparatively easy for the people to accomplish only if they will proceed on true lines of co-operation. If the people will co-operate with each other in their efforts, if they will put their shoulders to the wheel, if they will contribute each his little mite in money, in good-will and in energy this great problem can be solved. Co-operation no doubt will require some sacrifice, but that sacrifice will bring in immensely beneficial results only if people know how to wait and work and when the time for reaping the harvest will come, as undoubtedly it will, the people themselves will be astounded by the enormous results of their joint efforts. The basic principles of co-operation will tell you how great the performance may be, if, as I have already indicated, people will join together in mutual good-will and with some present sacrifice but with an eye to the future. I will develop next how this can be done.

There are 1,758 villages in Bengal with a population of 2 to 5 thousand. Altogether 4,858,299 people live in these 1,758 villages. There are besides 162 towns and villages with a population of 1,084,422. Of these latter many are municipal towns, but some are not. Little over one million of this last class live in non-municipal villages. In villages with a population of 2 to 10 thousand it is comparatively easier to do useful work than in villages with a population of, say, 500 to 1,000 or less than 500. I say it is easier to do useful work because in these more populous areas we are likely to get more men of intelligence and public spirit and comparatively well-to-do men than in villages with a much smaller population. My suggestion, therefore, is that we should take up these more populous villages first. I suggest that we should start medical relief and anti-malarial societies in some of these more populous villages. In a village with a population of, say, 5,000 it ought not to be very difficult with some amount of propagandist work to get together in the course of a year or two, say, about 200 persons who will agree to join in a co-operative organization for medical relief and anti-malarial measures. In the beginning perhaps the number will be very much less. I suggest tentatively that these proposed co-operative societies should have three classes of members. The first class member should pay, say, 12 annas to Re. 1 a month, the second class, say, 6 annas to 8 annas a month, and the third class, say, about 3 to 4 annas a month. The actual monthly payment for membership would obviously vary according to local condition, but I take the figures mentioned as a basis for discussion. I suggest that the first class member will have the privilege of having medical attendance free at his own home and will get medicine

* (See Report of the Land Revenue Administration of Bengal.)

at cost price. The second class member will get medical attendance free at the house of the doctor, but will also have the further privilege of being treated by the doctor in his own home in case of serious illness or in the case of illness of female members who ordinarily are *pardanashin*. In order to prevent the abuse of this latter privilege I suggest that these second class members will have to pay a nominal fee of, say, 3 or 4 annas per visit to the doctor in case he has to be called in for the purpose mentioned above. They will also have the privilege of getting medicine at cost price. The third class members, I suggest, should have all the privileges of the second class member, but such privileges will be limited to a period of, say, about 2 to 3 months in the year. The third class memberships are intended mainly for men who ordinarily have to live away from their villages for their vocational existence, but who keep some connection with their village homes. Over and above the monthly fees I suggest that the members should pay an admission fee of Rs. 3 to Rs. 4 payable in two instalments. This admission fee should be in the nature of capital paid on which members will be entitled to earn a dividend in case the society makes a profit. If, however, the members fail to pay their monthly subscriptions they will forfeit the amount paid as admission fee and will also forfeit all privileges of membership. On the aforesaid figures I do not think it will be very difficult to secure an income of Rs. 150 to Rs. 200 a month if there is steady and earnest work for a period of 1 to 2 years. At the beginning perhaps, the income will be very much less, say, Rs. 50 to Rs. 75 a month. I suggest that a percentage of the total income should be spent for the salary of a doctor and his compounder, another percentage for the upkeep of the dispensary, a third percentage for anti-malarial and sanitary work and the balance of 10 to 15 per cent. may be set apart for contingencies, sinking fund and a building fund. The doctor will have the liberty of private practice amongst non-members and the medicine of the dispensary will be sold at a fair price to non-members. This last business will bring in some profit to the society. The percentage set apart for anti-malarial and sanitary work should be spent for (a) clearing jungles in homesteads, gardens and waste lands and arranging the cultivation of some suitable crop so as to make jungle clearing an economic success, (b) providing and maintaining village drainage, (c) filling up insanitary ponds and cesspools, (d) so long as money is not available for filling up, dewatering or chemically treating small ponds and depressions used for steeping of jute after the steeping operations are over, (e) if so advised, chemically treating drinking water so as to make such water comparatively wholesome, (f) provision for boiled water and use of comparatively inexpensive filters in some central place, say, at the dispensary or at the doctor's residence, and (g) spread of sanitary knowledge generally and inducing people to adapt themselves to sanitary habits. In the above outline I have not indicated the actual percentage that I would set apart for the various activities of the co-operative society, for the figure will differ according to local conditions, local ideas and local inclinations. In a village where there is no competent medical man it will be necessary to import one. For such a village I suggest (on the basis of an income of Rs. 100 a month for the Society) that 45 per cent. may be set apart for the salary of a doctor who may usefully combine in himself the office of Secretary to the Co-operative Society, 10 per cent. for that of the compounder who may combine with his compounding duties the office of a *mohurir* to the co-operative society, 5 per cent. for the deficit, if any, for running the dispensary, 25 per cent. for anti-malarial and sanitary measures and the balance 15 per cent. for contingencies, sinking fund and building fund. I will provide further that the co-operative society will be at liberty to receive donations or subscriptions from persons charitably inclined or from the Government and local bodies. From the admission fees of the members perhaps Rs. 400 to Rs. 500 may be expected and a small dispensary may be started on an initial outlay of about Rs. 400 to Rs. 500. If a particular society cannot at the initial stage get together sufficient number of members it may be permitted to raise 2 to 3 hundred rupees by loan and that loan can gradually be paid off as membership increases and so long as membership does not increase the interest may be paid from the 15 per cent. set apart for contingencies, sinking fund, etc. If, however, membership does not increase rapidly a portion of the debts may be slowly paid off from the sinking fund

and in such a case perhaps the percentage set apart for sanitary measures and for the salary of the medical man may have to be reduced.

In villages where there is a competent doctor I would suggest that the services of the doctor who is already on the spot should be utilized and in these villages perhaps 35 per cent. of the total income may suffice, for the doctor will have the liberty of private practice. No doubt as membership increases, the facilities for private practice may decrease to some extent, but then increase of membership means a larger income to the doctor. I have prepared a set of draft bye-laws for these societies and I shall be very happy to distribute these draft bye-laws to persons who are really interested in this scheme. The draft bye-laws are only intended to be a provisional draft which may be useful as a basis of discussion for persons who are interested in starting co-operative societies on the lines indicated above.

In an earlier part of the address I have mentioned that I should like to start this work in the more populous villages and have also mentioned that the total population of these villages is about 6 millions out of the total rural population of 42 millions for the whole of Bengal. As soon as a co-operative society is firmly established in some of these more populous villages it will not be difficult to extend the membership to other outlying villages which are less populous so that in course of time the network of co-operative societies on the above lines may spread practically all over Bengal. Those who are really interested in this problem and who desire to take up this work as a practical problem can at the present moment examine for themselves the societies which are now at work at Panihati, Sukchar and Sodepore in 24-Pargannas. These societies owe their existence mainly to the energy and public spirit of Rai Bahadur Dr. Gopal Chandra Chatterjee. The practical working of these societies shows that the aforesaid scheme is a workable scheme and a scheme which can very well be taken up by those who are interested in the well-being of their villages, or in the problem of improving the sanitation of Bengal.

There is one aspect of the scheme to which I should like to draw your attention. Ordinarily people may not have public spirit enough and may not be long-sighted enough to organize co-operative societies merely for sanitary improvement, but I do expect that the provision for medical relief at a nominal cost is a tangible benefit which will appeal to most people, and people who will be attracted by the tangible benefits of medical relief will very soon realize that the benefits of sanitary improvement are equally tangible and perhaps far more effective. As sanitary work means prevention of disease, people will also realize, as these societies go on with their work, that diseases are preventable and that if organized work be undertaken on sanitary lines the results are perhaps far more effective and far more satisfactory than mere medical relief.

I have given you, gentlemen, the broad outlines of the scheme. I will now crave your patience for a short examination of some of the indirect benefits which we may expect from a successful working of this scheme. One benefit we may expect is the more extended employment of the poor man's doctor. Such employment will also mean to some extent the solution of the bread problem for the poorer middle classes. It will divert some men of these classes from attempting to seek employment in overcrowded clerical and other lines where he is not wanted and in employing him in a vocation where he will be a very useful member of society. At the present moment we have only 3,000 registered medical men all over Bengal. Of these 3,000, the bulk are to be found in the municipal areas where three millions out of over 45 millions reside. If I may make a guess I shall not be far out if I say that 2,000 out of these 3,000 practise in municipal areas. We have therefore only about a thousand qualified medical men to minister to the needs of a population of 42 millions, or in other words, we have only one medical man to a population of 42,000. In European countries the number varies from 1,200 to 2,000 to one medical man. No doubt European countries generally are far wealthier than Bengal, but Bengal is far unhealthier than any European country. From these figures you can at once appreciate the paucity of qualified medical man that we have in rural Bengal. Considering the comparative poverty of our people and taking into account at the same time the more insanitary condi-

tions of rural Bengal as compared with European countries if we aspire to have one medical man to a population of 3,000 we shall require 14,000 medical men for rural Bengal alone or in other words we shall require 13,000 more medical men for rural Bengal.

Another indirect benefit will be that it will help in providing rural Bengal with men of some education and intelligence. At present rural Bengal is practically denuded of men of education and intelligence. At the present moment our total number of graduates living in this presidency is about 14,000 and our total number of matriculates is about 80 to 90 thousand. The graduates and the matriculates mostly seek for a vocational existence in the municipal areas and in more or less literary or clerical occupations. This naturally results in great congestion and makes it difficult for the poorer middle classes to make a living. This also means that in the rural areas where the basic wealth of the nation is made, where the back-bone of the nation resides, where everything which matters, everything which makes for national progress is to be found, is absolutely denuded of men of education and intelligence. It is a crying need for Bengal to find vocational existence for men of education and intelligence in rural Bengal. You cannot improve the sanitation of the people, you cannot improve the agriculture of the province, you cannot further the educational institutions, you cannot improve the economic conditions of the people unless you have more educated and intelligent men in the rural areas. By providing for more medical men you not only provide for a great necessity of the society, but you also provide for the vocational existence of a large number of men of a fair amount of education and intelligence in rural areas. The residence of men of this type will be immensely helpful in the solution of many pressing problems of Bengal. Further it is well-known that the bread problem of the poorer middle classes is a very serious problem at the present moment. Apart from other benefits, this benefit alone is worth working for.

I should like to address you now on another aspect. Supposing we are so fortunate as to have 300 or 400 of these societies in the course of the next three or four years the amount of sanitary information which will be possible for us to collect will be immense. If through the doctors in charge of these societies the spleen census of patients be taken, the records of diseases and cases be tabulated and various other useful matters collected you can well understand what valuable material will be available to the Sanitary Department and to workers in the cause of the advancement of medical and sanitary science. I have no doubt that the information which it will then be possible to collect at a comparatively small cost would be so valuable that the future efficiency of the Sanitary Department will be immensely improved. The existence of these societies will also help so considerably the spread of sanitary knowledge that we may seriously hope for a real improvement in the spread of such knowledge in the province.

The next aspect of the indirect benefits of this scheme that I desire to place before you is that spread of these societies will make many men of the *bhadralog* classes more intimately interested in the progress of the co-operative movement. The main activities of the Co-operative Department at the present moment is in the field of agricultural credit. That is a question which affects the agriculturists more intimately than the *bhadralog* classes. No doubt there are *bhadralog* workers, either actuated by a zeal for the well-being of the agriculturists or connected with the more important co-operative banks, who are connected with the co-operative movement even at the present moment. But as I have said agricultural credit is a thing which touches the agriculturists more than the *bhadralogs*. The societies of the type that I have mentioned will touch the *bhadralogs* in the rural areas quite as much as the agriculturists in those areas. It is therefore natural to expect that with the spread and progress of these societies the *bhadralogs* in rural areas as also the educated middle classes generally will soon learn to take a more active and more extended interest in the working of co-operative societies. They will also learn to join in this common work with the agriculturists on a question vitally affecting them both, for I have no doubt, that in most of these societies the members will be agriculturists as well as the *bhadralogs*. It will help the *bhadralogs* to learn the problem of the agriculturists and it will bring about a better understanding between the *bhadralog* classes

and the agricultural classes. This undoubtedly will prove to be a very important factor in the progressive development of our province.

Another indirect but very important benefit of this movement will be to teach the people a great lesson, the practical lesson of self-government. It will teach the people the great lesson of work by the people and for the people. It is by successful practical work on lines such as these that the great lesson of mutual trust and mutual confidence will be learnt and by such knowledge alone the arduous problems of responsible government can be solved. So that I may claim that work such as this is the foundation-stone of the great edifice of self-government, which we Indians at the present moment are so anxious to raise, but whose dangers and difficulties some of us are perhaps so prone to overlook.

Lastly it will teach the people the great lesson of self-reliance. It will teach them how by the co-operation and good-will of a large number of apparently insignificant persons difficult and vital problems of the nation can be solved—problems which I have indicated in an earlier part of this paper and which baffle the Government and the wealthy at the present moment. It will teach the people how to work for the common good of many. May I in this connection remind you of a lesson with which every Hindu school boy who has read his Ramayana is familiar, namely, the lesson of help which the insignificant but numerically large number of squirrels rendered to the great Rama in the building of his bridge to Lanka. It is hardly necessary to tell you, mainly a Hindu audience, what that lesson is. I only ask you to realize for yourselves the truth of that lesson.

No great and lasting work can be done unless we have strength enough to overcome difficulties. Difficulties, there will be and perhaps many. There will be dark days of struggle, there will be days when the workers will feel almost beaten, when they will fear that the task undertaken was too great for their strength. In days such as these a little optimism is heartening. The bright side of the picture, a vision of success, is always encouraging. May I therefore take the liberty of presenting before you a vision, at the present moment nothing but a vision, for nobody knows better than I do that visions are visions—they do not often materialize. At the same time there are visions which lead us on to victory, and if the vision of the future success is a thing not to be neglected or despised the vision that I hold up before your eyes is a Bengal free from malaria, free from preventable diseases, healthy, wealthy and a strong Bengal, a Bengal which the Bengalees themselves with the co-operation, good-will and help of British officials and non-officials have built up. I may relate to you the vision as it unfolds before my eyes. I see the people of the Burdwan Division, the Rarh of ancient Bengal, have got back their reputed physique, the villages teeming with sturdy and stalwart men for which ancient Rarh was so famous. I see the districts of Jessore and Nadia, once the home of culture of Western Bengal, populated by a happy and smiling population free from malaria. I see East Bengal, the Banga of ancient Bengal, has wakened up in time and has escaped the horrors of disease and physical suffering which, alas, was so common in West Bengal for long long years. I see before me the *Barendra-bhumi* of Bengal after a period of keen and healthy emulation with the Rarh country have come out victorious and have got back some of the glories for which the *Barendra* land was so justly well-known in the old days. I see a central society established in Calcutta in close touch with innumerable societies spread all over Bengal organizing medical relief and sanitation and providing for the distribution of medicine at a rate so moderately low as to stagger our present ideas on the subject. I see a group of eminent medical men and earnest scientific workers working assiduously at the head-quarters, men who are overwhelmed with such wealth of materials that they find it difficult to cope with their work but who none-the-less with indomitable energy ultimately succeed in tackling various problems of health and relief which baffle the most eminent men at the present day and who are sending forth to the world new discoveries, new methods of treatment, new ideas of medical relief, in such quality and profusion as to make the name of Indian medical men and scientific workers—Europeans and Indians—honoured names in the pages of the world's

progress in science and medicine. I also see before me a Bengal first united in its efforts to fight the common enemy—malaria—learn the lesson of unity and joint action, realize the full fruits of that lesson in other departments and activities of national progress. I see a Bengal after full realization of such lesson walking along the path of agricultural progress, making two crops grow in a field where only one indifferent crop grows at the present moment. I see a wealthier stronger and a united Bengal vigorously tackling next the problems of economic, sanitary and educational progress. I see a Bengal with its jute presses more plentiful than the cotton ginning presses in Guzrat, Khandesh and Berar. I see a Bengal which has solved its drainage problem, which has solved its problem of

water-ways and which is at last on a fair way to making industrial strides unthinkable at the present moment. On the side of our educational activities I see a Bengal with primary schools in every village with a population of 500 or more, with grammar schools in every village with a population of 2,000 or more, with a university in each division sending forth their alumni in the great cause of the education of the people and advancement of world's knowledge. In short a Bengal which has learnt to adjust herself to her own requirements, which has learnt to build up a society with component parts each suited to the requirements and necessities of the other components. I will let the curtain drop here, for after all it is nothing but a vision. But though a vision it is up to you to make it a reality.



